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Information on an international survey on policies and practices in sheltered employment was conducted by questionnaires in English and Spanish in 65 countries, and by interviews in India and the United States. For convenience this report retained the traditional words "sheltered workshop," even though leaders in some countries are beginning to abandon the phrase because of its association with terminal employment. Information is reported from the 37 responding countries, where 2,800 workshops are employing 180,000 people. These data indicate that the sheltered workshop is a significant factor in economic, social, and rehabilitation planning. Extensive tables and charts contain information on the size and composition of programs, goals of sheltered employment, ownership and control, production and sales, management and labor. (CH)

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SHELTERED EMPLOYMENT OF THE DISABLED: AN INTERNATIONAL SURVEY

by

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U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION

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SHELTERED EMPLOYMENT OF THE DISABLED:
AN INTERNATIONAL SURVEY.

2

~~By~~ WILLIAM A. Glaser

A Research Project Conducted by the
World Commission on Vocational Rehabilitation. ~~of the~~
3 International Society for Rehabilitation of the Disabled.

10 Survey conducted
In Connection with the
International Seminar on Sheltered Employment
~~Held in~~ (Stockholm, ~~Sweden,~~ September 21 — October 1, 1964)

Through a Grant from the
* Easter Seal Research Foundation, of the
4 National Society for Crippled Children and Adults, Inc., Chicago, Ill.

Published by the
Swedish Labour Market Board
Stockholm, Sweden
January, 1966

Providing Work for the Disabled of the World

The International Society for Rehabilitation of the Disabled and its World Commission on Vocational Rehabilitation are deeply indebted to Sweden for the leadership and support it has given to the development of vocational rehabilitation services for handicapped throughout the world.

In particular, we are indebted to Mr. Albert Bergh, Chief of the Vocational Rehabilitation Division of the National Swedish Labour Market Board and his able assistant, Mr. Torbjörn Sundqvist, for their special efforts in advancing vocational rehabilitation. In 1955, Mr. Bergh and Mr. Sundqvist served as Chairman and Secretary of an international seminar on Selective Placement of the Handicapped — sponsored by the Swedish Government, the United Nations, the International Labour Organisation, the World Veterans' Federation and the International Society for Rehabilitation of the Disabled.

The benefits of the meeting were widespread and the published report became a basic document in the international vocational rehabilitation field.

The International Seminar on Sheltered Employment, held in Stockholm, Sweden from September 21 to October 1, 1964 was sponsored by the International Society's World Commission on Vocational Rehabilitation in cooperation with the Government of Sweden and the International Labour Organisation.

More than fifty representatives of governmental, international and voluntary organizations from thirty-five countries participated in the ten-day meeting. Again Mr. Bergh and Mr. Sundqvist accepted responsibility for organizing the meeting.

The program for the Seminar was a sequel to the European Seminar on Sheltered Employment held at The Hague, Netherlands, in 1959 under the sponsorship of the Netherlands Society for the Care of the Disabled.

An International Survey on policies and practices in sheltered employment was the basis for the 1964 International Seminar on Sheltered Employment. The need for such a survey was expressed to the Easter Seal Research Foundation of the National Society for Crippled Children and Adults of the United States. Subsequently, the Foundation made a grant to the International Society to carry out the research project that is reported in the following pages.

The International Society wishes to express its appreciation to Dr. William Gellman, Director, the Board of Trustees of the Easter Seal Research Foundation and the National Society for their assistance in carrying out the Survey.

Dr. William A. Glaser, Senior Research Associate of the Bureau of Applied Social Research of Columbia University, designed and carried out the project. We were fortunate in having Dr. Glaser on the project as he had both recognized research competence and international experience in this type of research project.

This project could not have been conducted without the cooperation of those who responded to the questionnaire. Their names are carried in this publication. Each one has made a personal contribution to international cooperation and has helped us to take one more step forward in the solution of vocational rehabilitation problems internationally.

The World Commission on Vocational Rehabilitation was established in 1960 by the International Society. Under the leadership of Mr. Ian Campbell, National Co-ordinator of Civilian Rehabilitation of the Canadian Department of Labour, the Commission has been a dynamic force initiating and uniting international efforts in this field.

A demonstration grant from the Vocational Rehabilitation Administration of the United States Department of Health, Education and Welfare to the World Commission on Vocational Rehabilitation has made possible the extensive program of the Commission which includes the Survey and Seminar as well as many other important international activities in vocational rehabilitation.

The Survey has already produced significant results. The fact that it is able to report on 37 countries where 2,800 work shops are employing 180,000 people has already made various groups more aware of the importance of sheltered employment. This shows beyond doubt that sheltered employment is a significant factor in economic, social and rehabilitation planning.

The Survey was of utmost importance to the 1964 Seminar and to the conclusions reached. For the first time participants in such a meeting were provided with information on sheltered employment practices and problems in all regions of the world. In turn, the conclusions of the Seminar may be applied globally.

The Survey itself proved that an intense, in-depth, international survey could be sucessfully carried out in the field of rehabilitation using the facilities and services of the International Society. Techniques have been demonstrated which will produce meaningful, comparable information from as many as thirty-seven nations in all regions of the world. Finally, the Survey has made us more keenly aware of the many areas in vocational rehabilitation needing research.

The Survey has already taken its place as an important international vocational rehabilitation document. It is now an integral part of a series of activities designed to enhance the provision of vocational rehabilitation services and employment for disabled persons throughout the world.

Donald V. Wilson

Donald V. Wilson
Secretary General
International Society for Rehabilitation of the Disabled

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Sheltered employment refers to the occupations and work sites specially adapted to the needs and capacities of disabled persons. Sheltered workshops are the installations where the disabled produce goods and services.

In order to stimulate the quantity and quality of sheltered employment, several international conferences have been held during the last decade. A companion volume to this is the report of the International Seminar on Sheltered Employment, conducted in September 1964 under the joint sponsorship of the World Commission on Vocational Rehabilitation of the International Society for Rehabilitation of the International Society for Rehabilitation of the disabled and the National Labour Market Board of the Government of Sweden.[1] To secure information for the seminar participants, the International Society for Rehabilitation of the Disabled asked the Bureau of Applied Social Research of Columbia University to conduct a worldwide survey of basic facts, by means of questionnaires. This monograph summarizes the information gained from the survey.

During April and early May 1964 questionnaires in either the English or Spanish language were sent to the following sixty-five countries: Argentina, Australia, Austria, Belgium, Brazil, Burma, Canada, Ceylon, Chile, Colombia, Costa Rica, Czechoslovakia, Denmark, Dominican Republic, Ecuador, Eire, El Salvador, Ethiopia, Finland, France, German Democratic Republic, German Federal Republic, Ghana, Great Britain, Greece, Guatemala, Haiti, Honduras, Hong Kong, Hungary, Iceland, India, Indonesia, Israel, Italy, Jamaica, Japan, Korea, Lebanon, Malaysia, Malta, Mexico, The Netherlands, New Zealand, Nicaragua, Norway, Pakistan, Peru, Philippine Islands, Poland, Portugal, Republic of South Africa, Spain, Sweden, Switzerland, Thailand, Trinidad and Tobago, Turkey, the U.S.S.R., the United Arab Republic, the United States, Uruguay, Venezuela, Viet Nam, and Yugoslavia. We received completed questionnaires from the following thirty-five countries: Argentina, Australia, Belgium, Burma, Canada, Denmark, Eire, Finland, France, German Democratic Republic, German Federal Republic, Ghana, Great Britain, Hong Kong, Hungary, Indonesia, Israel, Japan, Lebanon, Mexico, the Netherlands, Norway, Pakistan, Philippine Islands, Poland, Republic of South Africa, Spain, Switzerland, Sweden, Turkey, Uruguay, Venezuela, Viet Nam, and Yugoslavia. The required information was secured by interviewing informants from India and the United States. Letters were received from the following nine countries stating that they lacked sheltered

---

Note: All footnotes are collected at the end of this monograph, beginning on page 68 workshops at present: Austria, Colombia, Dominican Republic, Ecuador, Ethiopia, Greece, Honduras, Korea, and Malta. Jamaica and Portugal were said to have some informal establishments lacking the formal organization that would make them sheltered workshops within the meaning of our survey. This monograph summarizes the information from the thirty-seven countries that were covered by questionnaire or by interview.

In nearly all cases, questionnaires were mailed to the national secretaries of the I.S.R.D.[2] Some filled the documents out themselves; others answered the questionnaires in collaboration with their countries' specialists in sheltered employment; others passed the forms on to the experts for them to answer in full. Our informants provided exact information when they knew other questions with their best estimates. Informants in Sweden, Switzerland, and West Germany performed special surveys of their own countries to get complete facts for their responses to us, other informants summarized the knowledge already possessed from personal experience by themselves and by other experts. Thus we have well-informed impressions about the situation in several dozen countries. Of course this monograph does not claim to be a definitive description of the organization of sheltered employment in the world: to produce such conclusions would require personal interviews with several informants in each country and the gathering of copious national statistics. Surveys conducted by mail are fallible: our questions may not have anticipated every situation in every country; some informants may have misinterpreted some questions; and thus some of our data may contain errors. But our survey is the necessary first step in accumulating more detailed and more reliable knowledge, since it identifies certain patterns in the world, and we hope that more exhaustive studies might be done on sheltered employment and on other topics in the future. If each country regularly gathers information about rehabilitation of the disabled, then international organizations will be able to conduct many successful world-wide surveys that can be vehicles for the sharing of knowledge and advice.[3]

Our informants' responses referred to the situations in their countries during 1963 or at the time of the survey in the spring of 1964. Thus our report is a snapshot taken of a rapidly moving field. Doubtless sheltered employment in many countries will be more extensive and will be organized differently in future years. Informants from Austria, Ecuador, Ethiopia and Greece told us that they lacked sheltered workshops at the time of our survey but would soon establish them.

This survey covers some types of sheltered employment but not all. Most questions concern sheltered workshops; a few ask about homebound work programs. In order to get sufficient information about workshops and not burden our informants with an excessively long questionnaire, we did not ask about jobs in regular industry that are reserved for the disabled. Nor did we ask about "open-air" projects for the disabled, which are found in only a few countries.[4]

For convenience, this report will retain the traditional words "sheltered workshop." But leaders in some countries are beginning to abandon the phrase, because of its association with terminal employment, and they are seeking substitutes that will emphasize training and rehabilitation functions. Some Indians call them "production cum training centers," while some Americans refer to "protected workshops," "vocational adjustment centers," "industries," and other terms. In order to emphasize that it is the workers who are being sheltered and not the workshop itself, West Germans generally use the phrase beschützende Werkstatt (literally "sheltering workshop") instead of geschützte Werkstatt ("sheltered workshop").

Chapter 1: SIZE AND COMPOSITIONS OF PROGRAMS

a. Numbers of workshops and employees. Table 1 lists the number of workshops and number of employees throughout each country that answered our questionnaire. Some informants provided official statistics, others made estimates. The point in time varies among countries: some official statistics were gathered in the middle or end of 1963; most of the approximations refer to the late spring of 1964.

Table 1

Number of Workshops and Employees

Country	Workshops	Employees	Basis of Data
Argentina	3	131	exact statistics
Australia	71	4,666	exact statistics
Belgium	49	550-600	approximation
Burma	2	250	approximation
Canada	75	3,600	approximation
Denmark	40	1,200	approximation
Eire	10	300	approximation
Finland	20	1,200	approximation
France	50	2,000	approximation
German Democratic Republic	300	20,000	approximation
German Federal Republic	40	2,200	approximation
Ghana	2	68	exact statistics
Great Britain	171	11,765	exact statistics
Hong Kong	9	307	exact statistics
Hungary	6 major, 100-150 minor	20,830	exact statistics
India	9	220-270	approximation
Indonesia	6	206	exact statistics
Israel	50	1,050	exact statistics
Japan	380	18,700	approximation
Lebanon	4	100	approximation
Mexico	3	120	approximation
The Netherlands	194	17,893	approximation
Norway	25	490	exact statistics
Pakistan	10	1,000	approximation
Philippine Islands	2	52	exact statistics
Poland	68	3,898	exact statistics
South Africa	26	2,787	exact statistics
Spain	9	150	approximation
Sweden	119	6,990	exact statistics
Switzerland	55	1,940	exact statistics
Trinidad and Tobago	3	150	approximation
Turkey	3 or 4	300-500	approximation
United States	800	50,000	approximation
Uruguay	3	290	approximation
Venezuela	2	15	approximation
Viet Nam	4	500	approximation
Yugoslavia	80	4,000	approximation

Table 1 arranges countries alphabetically. Obviously countries differ considerably in the scope of their programs; in the sharing of experience, the more developed programs can yield more lessons than can the less developed.[5] Therefore many of the later tables in this report will classify the data in two ways: the responses from all countries together, and the responses from the "larger countries," where the latter are defined as those having more than 1,000 persons in sheltered employment. By this criterion, the larger countries are Australia, Canada, Denmark, Finland, France, German Democratic Republic, German Federal Republic, Great Britain, Hungary, Israel, Japan, The Netherlands, Pakistan, Poland, South Africa, Sweden, Switzerland, the United States, and Yugoslavia. With a few exceptions (notably Belgium and Pakistan) the nations with the larger programs are the more developed countries, while the others are the less developed societies. In our tables that present statistics for both our entire sample and for the larger countries, the reader can make his own comparisons of sheltered employment in developed and underdeveloped countries by subtracting the statistics for the "larger countries" from the totals for "all countries."

As specialists in the field know, a questionnaire can ask about sheltered workshops and a report can present apparently unambiguous statistics counting them, but the criteria of what is and is not a sheltered workshop are not clear-cut. Several authors have pointed out that the theoretical definitions set forth by some official bodies would exclude certain establishments in that country that are normally thought to be sheltered workshops.[6] And it is particularly difficult to adopt criteria that apply equally well to all countries: for example, certain managerial and rehabilitation services might be considered in some developed societies to be essential features before an establishment could be called a "sheltered workshop," while some would not be prerequisites in countries with less developed or otherwise different programs.[7]

In Table 1 and in the rest of this monograph, we have let each informant decide what are commonly considered "sheltered workshops" in his country, and we have not required all our informants to adopt a single definition dictated by us. Many countries provide remunerative occupational therapy or remunerative occupational diversion for the disabled and elderly, and our informants had to decide how much of this should be classified as sheltered employment. In practice, as our Indian informant pointed out, leprosaria provide livelihoods and work for many people in many countries, but the leprosy problem is so different from the adjustment of other disabled workers in their own home communities, that the leprosaria might not be counted as sheltered workshops. Thus nearly all our informants omitted leprosaria and lepers from the statistics presented in Tables 1 and 2. But a more ambiguous case is the work provided in many homes for the aged. Some of our informants reported that these programs were considered to be sheltered workshops in their countries and counted them in their responses to our survey, but other informants did not have such programs in their countries or did not count them.[8] In any future surveys of sheltered employment or in exchanges of advice, leaders in international activities concerning the disabled might have to settle such problems of definitions and classification.

Another example of the problem of defining a sheltered workshop is Yugoslavia. Most experts are accustomed to thinking of workshops as exclusively for the disabled. But in workshops in Yugoslavia and in some other Eastern European countries, disabled employees are matched by an equal number of the able-bodied. The disabled must work along with and emulate the normal workers, as the standard for their vocational rehabilitation.[9] The Yugoslavs (and we) believe these are sheltered workshops, because they contain all the usual medical and social services. But some other observers believe that the presence of so many normal workers and the maintenance of an industrial schedule make these establishments something else.[10]

Some guesses can be made about the average size of each country´s workshops, on the basis of Table 1: some countries have average sizes as small as twenty-five workers, others as high as 125. Probably most workshops in each country are somewhat smaller than the national average; this is particularly likely in the countries with many workshops, since a few large establishments can account for many of the country´s workers and thus raise the average.[11]

b. Composition of sheltered employment by disability. Each informant was asked to estimate the distribution of the country´s total labor force in sheltered employment according to primary disability. Most gave informal guesses, but a few countries could supply official statistics. Table 2 reports the number of countries that include each type of disability in their sheltered workshops, while

Table 3 presents the approximate distribution for each of the countries answering the question.

Some conditions are found in special workshops or in general workshops in nearly all countries, namely limb disabilities, tuberculosis, and blindness. As the scope of a country´s program increases, it adds mental illness, epilepsy, and retardation--i.e., the larger programs in the developed countries cover these conditions, while the smaller programs in the less developed countries usually do not. The smaller programs tend to consist of a few special workshops and thus each such program tends to emphasize a particular disease: usually a majority of the workers in such a program is blind or has limb disabilities. The blind constitute the largest proportion of workers in the greatest number of countries, but several countries differ. Some experts in vocational rehabilitation believe that sheltered employment will play an important role in the lifelong care and social adjustment of the mentally retarded. If so, sheltered employment for the retarded will constitute a large proportion of each country´s workshop population; but at present, only a few countries have as many as one thousand retarded persons in workshops.

Table 2

Types of Disabled Person in Sheltered Workshop

Disability	All Countries	Larger Countries
Amputees and other limb handicaps	32	16
Paraplegics	28	15
Persons recovered from tuberculosis and other lung diseases	29	18
Persons recovered from cardiovascular diseases	22	14
Blind, impaired vision	29	17
Deaf, impaired hearing	23	17
Persons suffering from leprosy	10	2
Persons suffering from cerebral palsy	24	13
Arthritics	24	15
Epiliptics	18	15
Mentally ill and persons recovering from mental illness	22	15
Mentally retarded adults	23	15
Mentally retarded children	5	4
Elderly	9	8
Total number of countries answering the question	35	18

A few informants mentioned other categories in their countries. such as alcoholics, the socially unadapted, persons suffering from intestinal complaints, persons suffering from cancer, etc. Numbers in this and in later tables are the numbers of countries who answered each question positively.

Table 3 (Part 1)

Distribution of Sheltered Workers by Disability in Per Cent: Larger Programs

Categories of Disabled Persons	Australia	Canada	Finland	German Democratic Republic	German Federal Republic	Great Britain	Japan	Netherlands
Amputees and other limb handicaps	13 %	3 %	8 %	4 %	13 %	11 %	19 %	10 %
Paraplegics	1	3	1	10	2	2	1	5
Persons recovered from tuberculosis and other lung diseases	2	3	12	4	3	14	5	13
Persons recovered from cardiovascular disease	2	1	8	5	2	4	-	8
Blind, impaired vision	7	29	4	20	1	34	5	6
Deaf, impaired hearing	0	4	4	10	3	2	3	1
Persons suffering from leprosy	-	-	-	-	-	-	-	-
Persons suffering from cerebral palsy	4	3	4	21	7	4	2	-
Arthritics	2	6	1	4	1	2	1	4
Epileptics	0+	2	4	3	11	6	-	4
Mentally ill and persons recovering from mental illness	50	6	8	15	5	6	-	2
Mentally retarded adults	( ) (17)	27	4	4	31	3	8	23
Mentally retarded children	( )	-	8	-	9	-	1	-
Elderly	2	14	33	-	3	-	56	-
Others	-	-	-	-	-	( ) (11)	-	6
Unspecified but belong to above categories	-	-	-	-	9	( )	-	18
	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %
Total number of sheltered employees forming the basis of these estimates	4,566	3,665	1,220	20,000	2,230	11,000	18,700	18,000

The base numbers and the percentages should be interpreted as approximations rather than exact statistics. Some estimates are based on less than the full number of sheltered employees. For example, the 35,000 American employees in this table work in the shops that have received subminimum wage certificates under the Wage and Hour Law. Some of our informants could not estimate the composition of their workshop populations, and these countries have been omitted from Table 3.

Table 3 (Part 1) - Continued

Distribution of Sheltered Workers by Disability in Per Cent: Larger Programs

Categories of Disabled Persons	Pakistan	Poland	South Africa	Sweden	Switzerland	U.S.A.	Yugoslavia
Amputees and other limb handicaps	-	5 %	6 %	( ) (27%)	?	?	4 %
Paraplegics	-	-	2	( )	?	?	15
Persons recovered from tuberculosis and other lung diseases	22 %	22	7	5	7	?	2
Persons recovered from cardiovascular disease	-	1	13	?	16	?	6
Blind, impaired vision	33	57	26	2	-	16 %	25
Deaf, impaired hearing	-	1	4	2	6	?	1
Persons suffering from leprosy	17	-	-	-	-	-	2
Persons suffering from cerebral palsy	28	-	4	?	?	3	2
Arthritics	-	1	7	?	-	?	3
Epileptics	-	-	7	?	?	1	6
Mentally ill and persons recovering from mental illness	-	-	7	35	( ) (19)	?	3
Mentally retarded adults	-	15	18	?	( )	16	9
Mentally retarded children	-	-	-	-	-	-	-
Elderly	-	-	-	2	-	?	-
Others	-	-	-	-	-	14	23
Unspecified but belonging to above categories	-	-	-	27	52	50	-
	100 %	100 %	100 %	100 %	100 %	100 %	100 %
Total number of sheltered employees forming the basis of these estimates	1,800	3,903	2,784	6,529	1,940	35,000	4,000

The base numbers and the percentages should be interpreted as approximations rather than exact statistics. Some estimates are based on less than the full number of sheltered employees. For example, the 35,000 American employees in this table work in the shops that have received subminimum wage certificates under the Wage and Hour Law. Some of our informants could not estimate the composition of their workshop populations, and these countries have been omitted from Table 3.

Table 3 (Part 2)

Distribution of Sheltered Workers by Disability in Per Cent: Smaller Programs

Categories of Disabled Persons	Argentina	Belgium	Burma	Eire	Ghana	Hong Kong	India	Indonesia	Lebanon
Amputees and other limb handicaps	30 %	( ) (11 %)	92 %	-	-	20 %	92 %	17 %	4 %
Paraplegics	5	( )	2	2 %	-	1	1	0+	-
Persons recovered from tuberculosis and other lung diseases	5	-	1	16	-	2	-	15	-
Persons recovered from cardiovascular disease	5	-	-	-	-	-	-	-	-
Blind, impaired vision	3	21	-	23	37 %	63	7	50	61
Deaf, impaired hearing	5	-	1	-	-	3	-	3	-
Persons suffering from leprosy	-	-	-	-	63	9	-	15	-
Persons suffering from cerebral palsy	3	11	2	7	-	-	-	0+	35
Arthritics	-	-	1	3	-	1	-	-	-
Epileptics	-	8	-	16	-	-	-	-	-
Mentally ill and persons recovering from mental illness	1	( ) (43)	-	16	-	1	-	-	-
Mentally retarded adults	-	( )	-	-	-	1	-	-	-
Mentally retarded children	-	-	-	-	-	-	-	-	-
Elderly	-	-	-	-	-	-	-	-	-
Others	6	( ) (6)	-	-	-	-	-	-	-
Unspecified but belong to above categories	38	( )	-	-	-	-	-	-	-
	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %
Total number of sheltered employees forming the basis of these estimates	130	600	250	306	68	305	270	206	99

Table 3 (Part 2) - Continued

Distribution of Sheltered Workers by Disability in Per Cent: Smaller Programs

Categories of Disabled Persons	Mexico	Norway	Spain	Trinidad	Turkey	Uruguay	Venezuela	Viet Nam
Amputees and other limb handicaps	20 %	4 %	43 %	?	4 %	?	95 %	80 %
Paraplegics	3	5	3	-	2	?	-	2
Persons recovered from tuberculosis and other lung disease	3	12	5	?	16	-	-	8
Persons recovered from cardiovascular disease	3	5	7	?	6	?	-	-
Blind, impaired vision	-	6	21	75	-	-	-	6
Deaf, impaired hearing	-	3	-	-	4	-	-	-
Persons suffering from leprosy	-	-	-	?	16	-	-	4
Persons suffering from cerebral palsy	5	4	2	-	4	?	5	-
Arthritics	8	5	19	-	12	?	-	-
Epiteptics	-	6	-	-	2	-	-	-
Mentally ill and persons recovering from mental illness	-	30	-	?	12	-	-	-
Mentally retarded adults	3	10	-	-	10	28 %	-	-
Mentally retarded children	-	-	-	-	-	63	-	-
Elderly	50	-	-	-	12	-	-	-
Others	-	10	-	-	-	-	-	-
Unspecified, but belonging to above categories	-	-	-	25	-	9	-	-
	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %
Total number of sheltered employees forming the basis of these estimates	120	490	185	150	490	300	15	500

One of the issues in the management of sheltered employment is whether persons with certain disabilities should be segregated from the others.[12] We asked our informants whether they believed that persons suffering from some conditions should be mixed into general workshops or should be kept separate. Table 4 summarizes their responses.

Table 4

Recommendations about Separation of Employees

Question: Do you believe that any of the following categories of disabled persons should not be mixed in the same work rooms with persons of different handicaps?

	All Countries	Larger Countries
Amputees	1	1
Paraplegics	1	0
Spastics	1	0
Persons recovered from tuberculosis	6	2
Persons recovered from cardiovascular illnesses	0	0
Blind	6	3
Deaf	2	0
Persons suffering from leprosy	17	4
Persons suffering from cerebral palsy	0	0
Arthritics	1	0
Epileptics	5	2
Mentally ill	18	6
Persons recovering from mental illness	7	1
Mentally retarded adults	8	2
Mentally retarded children	11	4
Elderly	2	0
No persons should be separated solely because of category of disability	3	3
Total number of countries answering the question	35	17

In general, willingness to mix workers seems to vary by the size of a country's program. Informants from the smaller countries were familiar with systems consisting of a few special workshops; informants from the larger countries have witnessed the spread of general workshops. The latter are less likely than the former to recommend the segregation of persons with particular disabilities.

It is not so much the bare type of disability that should govern the decision to mix persons, commented some of our informants, but the severity of the cases. A few said they believed separate work was best for severely retarded adults, severely retarded children, and the mentally ill who were highly handicapped and who were behavior problems; but they would include the less disabled in general workshops. Some favored mixing of the negative cases of leprosy but segregation for the active cases. Some disabilities could be mixed into general workshops only if supervision was adequate and the proportions were kept low, commented some informants, and they listed as examples cerebral palsy, epilepsy, mental illness, and mental retardation.

Other informants noted that the feasbility of mixing depends on the combination of conditions. Several countries separate the motor-handicapped from the mentally handicapped. The blind and deaf should not be put together because of communication barriers, our Indian informant commented, but each group could be mixed with others.

c. Composition by sex and age. All countries reported that women as well as men worked in sheltered workshops. Usually there is no segregation by sex: twenty-six reported that usually men and women work in the same rooms, eight said that occasionally they work together, and only Turkey, Pakistan, and Venezuela reported that separation is the rule.

In only eight out of thirty-seven reporting countries do children-- i.e., persons less than sixteen years--work in sheltered workshops. Several informants said that laws against child labor precluded children; any work experience for disabled children took the form of occupational therapy. Of the eight countries reporting workshop participation by children, seven said they sometimes worked along with adults.

Chapter 2: GOALS OF SHELTERED EMPLOYMENT

a. Actual goals. Exactly what sheltered employment does and what it should do are much debated in the world. For example, one issue is whether sheltered workshops should be permanent sites for persons who cannot enter normal employment or whether a country's program should concentrate on preparing people for regular jobs. Therefore our questionnaire asked our informants to indicate all the aims actually pursued by sheltered employment in their conutries and, in addition, the principal aims. Also, we asked them their opinions about the desirable aims of sheltered employment.

Table 5 summarizes the reports about the functions actually performed by sheltered workshops and homebound programs. The first column shows the number of times that each of the listed objectives was checked as an aim (either major or minor) by the countries surveyed; the second column shows the number of times that each aim was mentioned as one of the principal goals of sheltered employment.

One of the striking facts in Table 5 is the prominence of permanent livelihood in the functions of sheltered employment in the world: compared to the other goals, it was listed more often in the entire series of aims (i.e., in column 1) and far more often among the principal functions (i.e., in column 2). A new trend in some developed countries is to organize workshops for training and rehabilitation rather than as terminal career sites,[13] but many countries retain a more limited conception. In supplementary comments, some of our informants explained why their workshops were designed in large part or predominantly to provide lifelong incomes for the handicapped. In many underdeveloped countries, unemployment is high, employers can choose the healthy workers, the disabled cannot move from workshops to normal jobs, and therefore workshops must provide the disabled with their permanent and only possible livelihood. Some developed countries, such as Switzerland, assign rehabilitation and training functions to special vocational and medical rehabilitation centers, try to place the disabled in regular employment, and thus define workshops as places for permanent work careers for the disabled.[14]

Table 5

Actual Aims of Sheltered Employment

Aims of Sheltered Employment	Number of Times Mentioned	Mentioned as Principal Aim
Providing a temporary livelihood for disabled persons before they resume normal jobs in the economy	25	14
Providing a permanent livelihood for some disabled persons who cannot be employed privately	35	28
Providing activity to prevent decline in morale	22	5
Testing the ability to work at normal jobs--i.e., testing their endurance, their ability to work a full day, etc.	22	3
Testing the willingness to work at normal jobs--i.e., testing their motivations and attitudes	19	1
Testing the ability to get along with people	17	0
Developing the ability to adjust to work situations in general	25	6
Training for particular jobs with particular skills	22	2
Medical treatment and physical rehabilitation	14	0
Improving the ability to get along with people	17	1
Total number of countries answering the question	37	31

The questionnaire presented the list of possible aims. The first column of the table consits of responses to the question "In our country today, these aims are actually pursued by sheltered employment (check as many as apply)." The second column consists of responses to the question "In our country today, this is (or are) the principal aim(s) of sheltered employment (Check one or two)."

b. Recommended goals. Table 6 summarizes the informants' opinions about what aims ought to be pursued by sheltered employment. The first column is the summary of the answers to the question asking them to check all desirable aims, whether major or minor, while the second column lists the number of informants who cited each aim as most desirable.

As in Table 5, one can see the importance of providing permanent livelihoods in the sheltered employment programs of the world. However, the provision of temporary livelihoods is emphasized more prominently in hopes than in practice:

among those who answered the questions, the proportion advocating the transitional character of sheltered employment (in Table 6) is larger than the proportion of countries that are actually supposed to practice it (in Table 5).

Table 6

Recommended Aims of Sheltered Employment

Aims of Sheltered Employment	Number of Times Mentioned	Mentioned as Principal Aim
Providing a temporary livelihood for disabled persons before they resume normal jobs in the economy	21	11
Providing a permanent livelihood for some disabled persons who cannot be employed privately	25	23
Providing activity to prevent decline in morale	18	2
Testing the ability to work at normal jobs--i.e. testing their endurance, their ability to work a full day, etc.	19	3
Testing the willingness to work at normal jobs--i. e., testing their motivations and attitudes	16	1
Testing the ability to get along with people	12	0
Developing the ability to adjust to work situations in general	19	6
Training for particular jobs with particular skills	15	3
Medical treatment and physical rehabilitation	11	2
Improving the ability to get along with people	15	1
Total number of countries answering the question	31	23

The questionnaire presented the list of possible aims. The first column of the table consists of responses to the question "In my opinion, these aims should be included in sheltered employment (check as many as apply)." The second column consists of responses to the question "In my opinion, this should be the principal aim(s) of sheltered employment (check one or two)."

Chapter 3: OWNERSHIP AND CONTROL

a. Ownership. Many different public and private organizations own and manage sheltered workshops in the world. Our questionnaire asked estimates of the approximate distribution of each country's workshops among the possible owners. Table 7 summarizes the results.

Column 1 of Table 7 lists the number of countries in our survey that listed each type of parent organization. The dispersion of ownership varies considerably: in some countries (e.g., Hungary, the Philippines, and Turkey) ownership is concentrated under one or two categories of owner (such as the national government or private charitable associations); while in other countries, many owners were checked. Ownership by private voluntary associations is found most often, but government management is common too.[15]

Column 2 of Table 7 lists the numbers of countries in which each type of ownership is dominant--i.e., the number of countries in which half or more of the workshops are owned by that particular category of parent organization. In the largest number of countries, workshops are owned predominantly by private charitable associations: this pattern is found in much of Western Europe (e.g., Belgium, France, West Germany and Switzerland) and in countries influenced by Western European traditions in vocational rehabilitation (e.g., Australia, India, Pakistan, and Lebanon). Systems of workshops owned predominantly by national or provincial government are found in countries with publicly owned economies or with other traditions of public responsibility (e.g., Hungary, German Democratic Republic, Turkey, Burma). A few countries have highly dispersed systems: for example, Holland's workshops are distributed widely among provincial governments, local authorities, private associations, independent managements, and various combinations of these bodies. Probaly most of the world's sheltered workshops are owned by non-governmental associations, since this is the dominant pattern in the United States and in other large countries.

Table 7

Ownership of Sheltered Workshops

Category of Owner	Number of Countries with Each Type of Owner	Number of Countries in which the Category Owns More than Half the Workshops
National governments	14	7
Provincial or regional governments	11	1
Local governments	11	2
Private voluntary associations	28	13
Churches and religious orders	9	0
Privately owned industry or farms	5	0
Government-owned industry of farms	3	0
Cooperatives of disabled persons	10	2
Trade unions	0	0
Independent ownership of workshops	5	1
Dispersed ownership (i.e., no one category owns half or more)		7
Total number of countries answering the question	37	33

b. Affiliations. We asked whether sheltered workships tend to be administered in association whith the programs of hospitals, factories, homes for the elderly, homes for children, or rehabilitation centers. In practice, most countries' workshops seem to be run separately from such organizations and are not located in medical or industrial complexes. Twenty-seven out of thirty-five countries reported that half or more of their workshops were administered separately.

However, connections with other medical and rehabilitation programs are not completely absent. Half or more of the workshops in the Philippines, Burma, Mexico, Pakistan, Venezuela, and the German Democratic Republic are connected with hospitals and sanatoria. Most of the Turkish workshops have some sort of affiliation with homes for the elderly. Several authorities in vocational rehabilitation have urged the inclusion of many worksshops in comprehensive rehabilitation centers, and India actually plans such a change in forthcoming years, but at present only Denmark, the Philippines and Viet Nam have such affiliations for as many as half their workshops.

c. Subsidies. In most of the countries surveyed, a number of workshops need subsidies from some outside source. No country reported that all its workshops are self-supporting, in the sense that all operating costs are met by the sales prices of the products. The number of workshops requiring subsidies is substantial: fifteen countries reported that all their workshops require subsidies, fourteen said that most need financial aid, and only five wrote that more than half the workshops are self-supporting.

As sheltered has spread in the world and as the costs of well-designed rehabilitation programs have mounted, many countris have debated how best to meet the gap between the earnings and the expenses of workshops.[16] Various sources and administrative formulae are used in the world. Table 8 lists the sources of subsidies to prevent operating deficits; in most countries, more than one source is available.

Table 8

Sources of Operating Subsidies for Workshops

Sources	All Countries	Larger Countries
Grants from the government	31	17
Contributions from private charities, fondations, and voluntary associations	24	13
Churches	8	6
Contributions from private industry	7	1
Contributions from government-owned industry	1	1
Social insurance funds	6	4
Contributions from cooperatives of the handicapped	2	1
Total number of countries	35	19

In nearly every country, subsidies come from some government agency, and in most countries the government is by the principal source of such assistance. Heavy reliance on central government grants is common even in countries where most of the sheltered workshops are owned by private associations and local authorities, such as Finland, Japan, France, Switzerland, India, and Hong Kong. In the replies to our questionnaires, only Ghana, Lebanon, and Venezuela lacked systems of grants from government Treasuries or from public agencies. In only a few other countries (United States, Australia, and Canada), did private charity and private associations give more than the government. A recent law has changed the situation in Belgium: at the time of our survey, private charity and private associations gave more than the government; but national governmental aid greatly increased in late 1964, and thereafter many workshops meeting the requisite standards received more from the government than from private sources.[17]

A variety of administrative mechanisms is used for government grants for operating workshops. The national government of Holland, according to certain formulae, pays proportions of the costs of wages, medical examinations, management, and social services at all recognized workshops. Belgium now has a special national fund to subsidize the wages and other operating costs of sheltered workshops that meet certain standards. Because Swiss workshops are considered permanent work sites for the chronically disabled and because their employment of such people is costly, all Swiss sheltered workshops get subsidies for each worker at a small daily rate--for example, about one franc per day--from the national Disability Insurance Fund (the Invalidenversicherung.) In the German Democratic Republic, the subsidies for the workshops are given in the name of the publicly owned industry. In Poland, the funds come from the cooperative association of the handicapped--one of the bodies in the public but nominally non--governmental sector of the society--that technically is the owner of all the sheltered workshops. Besides all such subsidies for operating costs, many governments provide construction grants, as we shall see in Table 9. (In addition to or instead of subsidies, many governments assist workshops by reducing or eliminating the taxes that normally fall on industry.)

In most countries, workshops' incomes come from some combination of sales and grants. The United States has a third important source of income, namely the fees from the state rehabilitation agencies. Over half the states have such units; they are responsible for the medical, social. and vocational rehabilitation of disabled persons referred to them by other medical and social agencies. The rehabilitation agencies refer many clients to sheltered workshops for vocational rehabilitation; over half the country's workshops have regular relationships with these agencies. The agencies request the workshops to perform several services, particularly the initial work evaluation of the client in a work situation, personal adjustment services. work adjustment services. and vocational training in particular fields. For these services, the state agencies pay fees to the workshops, and these fees become an important means of meeting the difference between total costs and income from sales. Our American informant estimated that one-sixth of the deficits of workshops might be paid through this source and that the state fees may be three as great as the total of all government grants.

d. Government support and regulation. Besides operating subsidies, goverments can furnish other kinds of support for sheltered workshops. Table 9 summarizez the responses to a question about government influence. As the reader can see, providing buildings and equipment is very common, although some countries have more generous programs than others.

For example, Switzerland has public building subsidies of up to one-third of construction costs for non-governmental workshops, while some other countries provide such building subsidies for private workshops only occasionally. When they exist, government grants are usually outright: fewer countries have systems of repayable loans; even then, the offers are made only occasionally and by the local rather than the more affluent national governments. Some governments provide certain assistance selectively rather than give it to all workshops; for example, the Belgian national government provides managers and medical services to the special workshops for disabled war veterans but not to all.

In generalizing about government influence upon workshops, of course, one must distinguish between the countries where public and non-governmental agencies own the workshops. Of the thirteen countries with predominantly owned workshops (according to the information summarized in Table 7), government provides buildings in eight, equipment in five, managers in two, managerial training in two, and medical services in four.

Table 9

Government Support and Regulation

Question: Do the national, provincial, or local governments influence sheltered workshops in any of the following ways?

	All Countries	Larger Countries
Legislation fixing standards for workshops even if no financial aid were supplied	14	8
Rules fixing standards for workshops as a condition for receiving government subsidies or government loans	20	13
Giving buildings and construction grants for sheltered employment	25	13
Giving equipment and equipment grants for sheltered employment	22	11
Providing repayable loans at no interest or at favorable rates of interest	11	7
Supplying managers	13	4
Training managers and other staff members	12	5
Providing medical services free or at little cost	15	6
None of these	3	1
Total number of countries	37	19

A few countries reported miscellaneous assistance. United States: grants for alteration of buildings for workshops; research and demonstration grants to workshops undertaking experimental programs. Hong Kong: free meals; travelling expenses; incentive payments.

The first two responses in Table 9 listed the number of countries who had special regulations about sheltered workshops. Table 10 shows the number of countries who have each type of regulation on their statute books. As one can see, the principal subjects of regulation are wages, hours, rest periods, safety and sanitation. and medical standards. In general, regulations are more common in the developed than in the underdeveloped countries.

Table 10

Subjects of Government Regulation

Question: If national, provincial, or local governments issue laws and rules about sheltered workshops, what do these regulations concern?

	All Countries	Larger Countries
Minimum wages	13	7
Maximum wages	8	6
Maximum hours of work	16	10
Rest periods for workers	13	8
Safety and sanitation in workshops	21	13
Types of handicapped persons that may or may not work in shops	8	4
The minimum medical services that workshops must have	12	9
The types of products that workshops may make	5	4
Prices of products	7	7
Procedures for selling or disposing of products	6	5
How profits may be used	7	6
None of these	8	4
No answer	4	0
Total number of countries	37	19

A few countries reported miscellaneous regulations. Netherlands: minimum hours of work. India: checking accounts and staff qualifications. Belgium, Netherlands, and a few other countries report that workshops are subject to the same regulations as in open industry concerning minimum wages, maximum hours, safety, sanitation, and other matters. But, we hope, the data reported by our informants in answer to this question and compiled in Table 10 refer only to the special regulations governing workshops.

Chapter 4: MEDICO-SOCIAL FUNCTIONS AND ORGANIZATION

As rehabilitation goals are increasingly urged in sheltered employment in the world, the literature in the field is developing a consensus about the testing, restorative, and relief services that should be included in the programs of each workshop. In addition, ideal workshops are pictured with staffs including certain specialists in testing, treatment, rehabilitation, and guidance.

Our questionnaire attempted to estimate the present extent of these services in the world's workshops and the roles played by various specialized personnel in providing these services. The following tables report the results. Since the tables may appear complicated at first inspection, we shall first explain how the information was secured. Each informant was asked whether his country's workshops offered certain services (for example. occupational therapy) or utilized certain personnel for certain purposes (e.g., whether physicians specializing in industrial medicine participate in the intake examination of workshop clients). A simple "yes-or-no" response would have been useless in estimating magnitudes: "yes" would have applied ambiguously to all countries that had few or many of the specified characteristics, while "no" would have identified only those countries completely lacking them. To get an estimate whether a characteristic was universal, common, rare, or wholly absent, the questionnaire asked whether it was found in "all workshops," "more than half", "less than half," or "none" of the workshops in that country. The following tables give the numbers of countries who are reported to have each characteristic at the reported frequency: for example, in Table 11, two countries are said to have physiotherapy in "all" their workshops and three countries have it in "more than half;" in Table 12, five countries have industrial physicians examining new employees in "all" their workshops, while one country involves such doctors in intake examinations in "more than half" of the shops.

Each table is divided into two parts, one to summarize all responses and the other to present the responses from the larger countries. In sharing experiences internationally, countries with many workshops and clients may appear more important than those with but a few workshops.

a. Social and medical services. Table 11 lists many of the social and rehabilitation services that are now commonly advocated for workshops oriented toward rehabilitation. As one can see, most workshops lack these services. Medical examinations are common, but certain other elements in a rehabilitation program -- e.g., vocational testing and vocational guidance -- are reported less often.

Table 11 summarizes only those services that are parts of workshops. A few countries reported that these services are available to all or most workshop employees, but under the auspices of another organization. For example, employees in Switzerland and Hungary get occupational therapy, physiotherapy, and prostheses from hospitals and medical rehabilitation centers. In France and Switzerland, vocational testing is performed by vocational rehabilitation centers before the client enters the workshop; in Sweden, such testing is done by special centers for the assessment of work capacity. Placement in normal employment is done by employment exchange offices in Holland and Sweden, and by vocational rehabilitation offices in Switzerland. In general, the workshop and rehabilitation office have a carefully designed division of labor in Switzerland, so that many of the client's needs are covered, but they are met outside the workshop to a possibly greater degree than in many other countries.

Services may be organized within individual workshops or within combinations. For example, nearly all of Belgium's workshops belong to larger associations, and these bodies provide for their constituent units the social casework counselling, relief and family services, recreation, and health education that elsewhere might be sponsored by the unit.

Table 11

Services Provided by Workshops

Question: Approximately how many of the sheltered Workshops in your country provide each of the following services?

(A). All countries: Proportion of workshops in each country:

Services	All	More than Half	Half	Less than Half	None	Services are Provided by Other Organizations	No Answer
Occupational therapy	3	3	1	12	10	2	5
Physiotherapy	2	3	0	9	14	2	6
Vocational or trade testing	5	4	2	11	5	2	7
Vocational guidance	7	6	1	7	5	3	7
Prosthetics fitting and training	4	1	1	9	14	3	4
Regular medical examinations	13	8	1	9	3	0	2
Service for placing persons in normal employment	7	6	2	9	3	3	
Social casework counselling	6	6	1	13	4	1	5
Relief and family service	3	9	2	6	10	1	5
Recreational program	7	5	1	13	5	0	5
Health education	6	1	1	9	7	0	12

Table 11, Part (B) Larger countries: (continued on following page.)

Table 11

(B). Larger Countries

Proportion of workshops in each country

Service	All	More than Half	Less than Half	None	Services are Provided by Other Organizations	No Answer
Occupational therapy	0	2	8	4	2	2
Physiotherapy	0	1	6	7	2	2
Vocational or trade testing	3	3	7	0	2	3
Vocational guidance	3	4	5	1	3	2
Prosthetics fitting and training	1	0	6	6	3	2
Regular medical examinations	8	4	5	0	0	1
Service for placing persons in normal employment	3	4	3	3	3	2
Social casework counselling	4	4	5	1	1	3
Relief and family service	3	5	2	5	1	2
Recreational program	5	3	7	1	0	2
Health education	5	0	4	4	0	5

The entries in Table 11 through 14 are the numbers of countries giving each response. Answers to this battery of questions came from 36 countries altogether and from 18 "larger" countries. "No answer"may have been given to some individual questions by informants who otherwise might have checked "none", but we cannot be certain. A few countries reported in supplementary comments that the services were provided to all or most workshops employees, but through other organizations; we have indicated those responses separately in the table, although possibly some of the unexplained "none" responses should have been included in that category too. Each line of Tables 11, 12, and 14 distributes the countries in the survey among all possible responses; therefore the total number of countries is the sum of the numbers on each line of the table.

b. Evaluation at entry. Our questionnaire asked about the kinds of specialist who participate in the evaluation of a disabled worker's physical, mental, and vocational abilities at the time he enters a workshop. Table 12 summarizes the results. The workshop manager, foreman, and social workers participate in intake avaluations in large proportions of the countries, but the use of other professionals is much less common.

A few countries reported that many of these professionals contribute to intake evaluations, but in the referring organizations before the client arrives in the workshop. This is the practice, for example, in Switzerland, Sweden, France, and Denmark. A few countries reported that some of these professionals are on call in workshops: they do not regularly participate in all intake examinations but consult whenever necessary. This is the case, for example, among social workers in the German Democratic Republic, and among industrial physicians, medical specialists in physical medicine, psychiatrists, physiotherapists, and occupational therapists in Hong Kong. A few countries reported that certain of the professions hardly existed anywhere as yet. For example, our Japanese informant said that professional training in vocational guidance, physiotherapy, and occupational therapy had not yet begun in Japan, and therefore the country's qualified specialists in these fields were a few persons with foreign training.

c. Evaluation during and at the end of employment. We asked whether workshop employees are given physical, mental, and vocational evaluations during employment and at the time of discharge. Table 13 shows the extent of these evaluations among the countries surveyed. Large proportions of workshops in many countries conduct no systematic evaluations. Ability to work is estimated more widely than physical and mental ability.

Table 12

Participation in Intake Evaluations

Question: Approximately how many of the sheltered workshops in your contry include the following professional specialists in the physical, mental, and vocational evaluation of the handicapped person at the time of his entry into the shop?

(A). All countries:

	Proportion of workshops in each country:						
Personnel	All	More Than Half	Half	Less Than Half	None	Services are Provided by Other Organizations	No Answer
Physicians specializing in industrial medicine	5	1	0	5	14	2	9
Physicians specializing in physical medicine and rehabilitation	2	8	3	11	5	3	4
Psychiatrists	1	2	1	16	6	3	7
Specialists in vocational rehabilitation	2	9	1	11	5	2	6
Psychologists	3	3	0	13	11	3	3
Physiotherapists	2	3	1	10	11	4	5
Occupational therapists	1	1	1	11	12	2	8
The manager of the workshop	21	6	2	3	1	0	3
The foreman of the production	11	7	1	5	2	0	10
Representatives from government agencies specializing in industry, agriculture or labor	4	1	0	6	14	1	10
Social workers or other specialists in social welfare	10	8	1	11	2	2	2

Table 12, Part (B) Larger countries: (Continued on following page.)

(Continued from previous page) Table 12

(B). Larger Countries:

Proportion of workshops in each country:

Personnel	All	More Than Half	Less Than Half	None	Services are Provided by Other Organizations	No Answer
Physicians specializing in industrial medicine	5	1	4	5	1	2
Physicians specializing in physical medicine and rehabilitation	1	4	7	2	2	2
Psychiatrists	0	2	10	1	2	3
Specialists in vocational rehabilitation	2	5	5	2	2	2
Psychologists	1	2	8	3	3	1
Physiotherapists	0	1	7	4	3	3
Occupational therapists	0	0	9	5	1	3
The manager of the workshop	13	3	1	0	0	1
The foreman of the production	8	5	1	0	0	4
Representatives from government agencies specializing in industry, agriculture or labor	2	1	5	5	1	4
Social workers or other specialists in social welfare	7	4	5	0	1	0

The table reports estimates of the proportion of workshops involved in periodic and terminal evaluation in some way. The sites of these evaluations seem to vary. In many countries, examinations are done in the workshops. A few countries, such as Switzerland, have extensive medical and vocational rehabilitation centers that are the sites for all such examinations and that employ the examining personnel. The rehabilitation agencies that deal with workshops in over half the states of the United States are the bodies calling for the evaluations and using their results; but these agencies delegate these tasks to the workshops and to professionals employed by the latter, in return for fees.

Table 13 simply counts the estimated frequencies of the evaluations in the reporting countries. Future research should ask about the thoroughness of examinations and the criteria for estimating capacities and progress of employees.

d. Personnel participating in periodic and terminal evaluation. Table 14 summarizes the reports about the utilization of various specialists in these examinations. The workshop manager and his staff appear to carry the responsibility in most of the workshops in most of the countries. Although our structured response required our informants to mark "less than half" when any of their countries´ workshops used a designated category of personnel, apparently there is a considerable range within this category. For example, the United States has only a few physicians practicing even part-time in a workshop setting, and the same is true in some other countries reporting that "less than half" their workshops used physicians. Similarly, certain other specialists are scarce in some countries that marked the "less than half" category: for example, our Yugoslav informant reported that few of his country´s workshops had physiotherapists.

Table 13

Periodic and Terminal Evaluations

Question: Approximately how many of the sheltered workshops in your country perform the following evaluations of the disabled person at the following times?

	Periodic Evaluation During His Employment at the Workshop		Terminal Evaluation at the Time He Leaves the Workshop	
Proportion of Workshops in Each Country	Evaluation of Physical and Mental Ability	Evaluation of Ability to Work	Evaluation of Physical and Mental Ability	Evaluation of Ability to Work
(A). All Countries:				
All	11	15	9	13
More than Half	6	7	4	7
Half	1	2	1	1
Less than Half	9	6	9	7
None	2	1	6	3
No Answer	7	6	8	6
(B). Larger Countries:				
All	6	9	7	8
More than Half	3	5	2	5
Less than Half	5	3	5	2
None	0	0	1	1
No Answer	5	2	4	3

Table 14

Participation in Periodic and Terminal Evaluations

Question: If evaluations of disabled persons´ abilities are made during or at the end of their employment, approximately how many of the sheltered workshops in your country include the following persons in the evaluation?

(A). All countries:

	Proportion of workshops in each country:						
Personnel	All	More Than Half	Half	Less Than Half	None	Services are Provided by Other Organizations	No Answer
Physicians specializing in industrial medicine	2	2	1	6	11	3	12
Physicians specializing in physical medicine and rehabilitation	3	5	3	12	4	3	7
Psychiatrists	0	2	1	16	5	2	11
Physicians in other fields, such as general medicine	7	6	1	8	6	2	7
Social workers or other specialists in social welfare	8	6	2	13	1	1	6
Specialists in vocational rehabilitation	6	8	1	9	4	1	8
Psychologists	2	4	0	14	8	1	8
Physiotherapists	2	1	2	10	11	2	9
Occupational therapists	1	0	2	11	11	1	11
The manager of the workshop	21	5	2	4	1	0	4
The foreman of the production	11	8	1	4	3	0	10
Representatives from government or from private agencies specializing in employment of the handicapped	3	2	0	6	13	1	12
Representatives from government or from private agencies specializing in employment of the ablebodied	2	1	0	9	11	1	13

Table 14

Participation in Periodic and Terminal Evaluations
(Continued from previous page)

(B). Larger countries:

	Proportion of workshops in each country:					
Personnel	All	More Than Half	Less Than Half	None	Services are Provided by Other Organizations	No Answer
Physicians specializing in industrial medicine	2	2	5	3	2	5
Physicians specializing in physical medicine and rehabilitation	1	2	8	2	2	4
Psychiatrists	0	2	11	1	1	4
Physicians in other fields, such as general medicine	5	2	6	2	1	3
Social workers or other specialists in social welfare	5	3	9	0	1	1
Specialists in vocational rehabilitation	4	5	4	2	1	3
Psychologists	0	3	9	2	1	4
Physiotherapists	0	0	7	5	1	6
Occupational therapists	0	0	8	5	1	5
The manager of the workshop	14	2	2	0	0	1
The foreman of the production	3	6	1	0	0	4
Representatives from government or from private agencies specializing in employment of the handicapped	1	2	5	6	1	4
Representatives from government or from private agencies specializing in employment of the able-bodied	1	0	7	4	1	6

Some (but not all) the informants in the "no answer" category in Table 14 indicated in the responses summarized in Table 13 that their countries had no or only rudimentary evaluations. A few but unknown number of others giving the "no answer" response in Table 14 may have evaluations, but the designated category of personnel may not participate.

Chapter 5: PRODUCTION AND SALES

a. Output and sales on own account and under contracts. We asked our informants to estimate the proportions of their countries´ workshops that "make/their/own decisions about what to produce and then sell the output on the open market" and, on the other hand, that "produce whatever is ordered by an industrial firm or government agency on a sub-contract, and turn all the output over to this customer for regular payments or for a single lump sum payment."[18] Table 15 shows the great variety in the world: each country seems to have evolved its own practices, and at present no single pattern dominates.

The trend is toward greater reliance on contracts. The Swiss informant reports that most of his country´s workshops are now changing over from their own retailing to industrial sub-contracting; at the time of our survey, about half the Swiss workshops were reported already to work on a contract basis. India´s workshops have also changed almost completely from autonomous retailing to contracts.

In some countries, several workshops still produce output on their own account, to supplement income from contracts or to fill slack periods. For example, the Australian informant said that all the country´s workshops depend primarily on contracts, but about one-quarter produce and sell some products on the open market.

In Table 15, most of the workshops making their own decisions do so individually. However, some countries have associations of workshops that make collective decisions about production and then sell all the output through wholesale and retail outlets. For example, about one-quarter of the workshops in the United States belong to national organizations -- such as Goodwill Industries, Volunteers of America, the Lighthouse, and

Table 15

Autonomy and Reliance on Contracts

	All Countries	Larger Countries
Three-quarters or more of workshops make own production and sales decisions	8	3
Between half and three-quarters, make own decisions	7	4
Half make own decisions, half depend on contracts	4	3
Between half and three-quarters depend on contracts	7	5
Three-quarters or more depend on contracts	10	4
Total number of countries answering the question	36	19

others -- that make collective decisions about production and then market the output through their own stores.

b. Length of contracts. Among the countries with contracts, most have time clauses as well as quantity specifications. But this is not true everywhere: in India, for example, contracts are let on a job basis and end whenever the workshop can deliver the specified number of objects.

Most of our informants were unable to estimate the approximate length of the average, shortest, and longest contracts in their countries. According to some, the shortest workshop contracts lasted a few weeks and the longest several years. A few estimated that the average contract in their countries lasted about a year. But in some countries, the average and longest contracts are considerably shorter: in particular, in the United States, anything over six months would be considered long; many workshops are finding their place in the fast-moving American economy by offering to supply hard-pressed companies with needed materials on short notice and in a short time.

c. Prices. Twenty-six countries were reported to offer workshop output at the same prices as the output of normal industry. In three countries prices were said to be higher, and in eight countries the prices are generally lower. In some of the latter countries, such as the United States, the retail salesmen and contract procurement men once believed that workshop produce could be sold only if prices were lower, and the tradition sometimes persists.

d. Labelling. We asked whether workshop output is labelled in each country, and Table 16 shows the results. In general, output sold on contracts usually is not labelled, but otherwise there is no general rule: some retailed output is labelled while some is not; a few countries label some of the production sold on contracts.

Because some doubtful enterprises attempt to sell merchandise to a sympathetic public, organizations in some countries have introduced official labels. For example the Swiss association for vocational rehabilitation (the Schweizerische Arbeitsgemeinschaft zur Eingliederung Behinderter in die Volkswirtschaft, customarily abbreviated S. A. E. B.) issues a special label that recognized workshops may affix to all merchandise. Usually it is pasted on products sold on the open market.

Table 16

The Labelling of Workshop Output

Question: Approximately what proportion of the output of sheltered workshops in your country is labelled as made by the handicapped when sold to customers?

	All Countries	Larger Countries
All of it	1	0
More than half	3	0
Between a quarter and a half	4	3
Less than a quarter	16	9
None	12	6
Total number of countries answering the question	36	18

Because labelling is one of the more controversial issues in sheltered employment, we asked our informants whether they favored it. Questionnaires from three countries said all products made by the handicapped should be labelled, thirteen said that some products should be labelled, and twenty opposed the identification of any.

Following are some of the argument for labelling:

> Because the products will be sold more easily (Turkey). We consider all /should be labelled/ because it is the way of accustoming the public that the disabled in appropriate jobs are capable of achieving equivalent work and capacity as normal workers (Argentina).
>
> It is a good support from the population to the war wounded (Viet Nam, where many workshop employees are wounded veterans).
>
> We believe that, since it is an incentive for the work of the sheltered persons, the sheltered person often performs very good work and thereby the self-pride of the sheltered person is raised (German Democratic Republic).
>
> Only as long as there is necessary any retail selling of products. Label will be unnecessary as soon as all workshops are getting enough subcontract orders by industry (Switzerland).

Certain arguments were offered against labelling:

> No, because that isn't rehabilitation. You must eliminate the sympathy for the handicapped (India).
>
> Products should be able to compete on the open market without sympathetic consideration. Some clients object to association with unhappiness or illness (Australia).
>
> Because labelling puts a stigma on the workshops and their workers (The Netherlands).
>
> Labels call in some way for charity. Sheltered employment should be competitive as much as can be (Belgium).
>
> The price being the same, labelling would diminish the possibility of sale. It wouldn't have the character of charity, as help is delivered anyhow, but in another form (Hungary).
>
> The product chould compete with its own quality. Labelling will discourage the disabled workers (Norway).

A few informants explained why some goods should be labelled but others not.

For example, our Irish informant said:

> As a rule it leads to a sympathetic and rather soft approach, as opposed to a business-like one with a feeling of achievement for the worker. In some instances, such as with the blind in small communities, it may not be possible to produce work that will sell without this extra appeal.

At least one informant found himself in a dilemma on the issue. One who marked his questionnaire "no" commented:

> I must distinguish between my personal and professional view. Professionally, I think that labelling is an effective emotional tool, particularly for selling the production of the blind. But my personal view is that it is not good to play up the disability factor. It is easier and better to come up with a better product. And our policy with the handicapped is that they should do the job. But when I was on the board of a shop for the blind, I had no qualms about allowing them to label, in order to sell the product.

An interesting fact is that arguments for and against labelling are based on contradictory factual assumptions. Some advocates believe that labels stimulate the ambition and pride of the disabled; some critics believe that labels have the opposite effect. Plainly this is the kind of empirical question that calls for research among the disabled and among the public as a basis for informed decisions.

e. Preferential buying. We asked whether sheltered workshops secure some customers as a result of preferences over competing normal industry. As Table 17 shows, many customers buy workshop output provided its price is competitive. But in only a few countries do customers buy workshop output in preference to cheaper products from normal industry. The latter type of preference is usually given by government agencies.

Usually the volume of such preferential buying is small. But occasionally a regular and substantial customer is obtained, particularly among hospitals and other social institutions owned by the government and by private charitable associations. For example, the local governments of Finland order their hospital bedlinens and some other hospital supplies from their own sheltered workshops.

In only one country in our survey do sheltered workshops enjoy a statutory monopoly over production of certain items: in Poland, the making of brushes and blinds is reserved to them.[19]

Table 17

Preferential Buying by Customers

Question: When seeking suppliers, do any of the following customers tend to give preference to sheltered workshops?

	Only if Sheltered Workshops Quote Same Prices as Most Favorable Private Bidder	Even if Sheltered Workshops Quote Less Favorable Prices than Private Bidders
(A). All countries		
Government agencies	17	5
Government-owned industry	8	2
Private business	19	3
Churches and religious orders	8	2
No such preferences are given by anyone	5	8
No answer	8	21
Total number of countries	37	37
(B). Larger countries		
Government agencies	10	2
Government-owned industry	5	1
Private business	8	3
Churches and religious orders	3	2
No such preferences are given by anyone	2	4
No answer	5	10
Total number of countries	19	19

Chapter 6: MANAGEMENT

a. The qualifications of managers. Table 18 summarizes some of the qualifications possessed by workshop managers in the countries surveyed. Our question defined a manager as "the individual who is the principal supervisor and director of all the affairs of the workshop." Training and experience in industrial management, industrial work, and social work are more common than are training and experience in other fields.[20] As some of our informants commented, many managers in many countries have no special professional training and simply happened to enter workshop careers as a result of humanitarian interest in the problems of the disabled.

Not many countries have significant numbers of doctors running workshops. Several informants indicated that "less than half" in our questionnaire should have signified "very few". The Yugoslav informant said doctors manage only the small number of workshops in hospitals and rehabilitation centers. A Belgian physician manages a shop for the mentally retarded.

b. Official regulations. Only four countries reported that the government or federations of workshops had rules prescribing that workshop managers must or ought to have any of the qualifications listed in our questionnaire. Poland, France, and the German Democratic Republic officially prefer previous training or experience in industrial management, industrial labor and social work. To this list, the German Democratic Republic would add prior experience in employment of the handicapped. Japan specifies such prerequisites as social work, rehabilitation, and a university degree.

Table 18

Prior Experience and Training of Managers

	Proportion of workshops in each country:					
Background of managers	All	More Than Half	Half	Less Than Half	None	No Answer
(A). All countries						
Experience in industrial management	5	8	0	12	10	2
Experience as an industrial worker	3	8	0	8	12	6
University degree	3	4	0	12	12	6
Training or experience in social work	2	7	3	16	5	4
Training as a physician	0	0	1	5	21	11
Training or experience in physical medicine and rehabilitation	0	0	1	4	22	10
Experience in the employment of the handicapped in fields other than sheltered employment	4	4	1	13	8	7
Managers are physically handicapped themselves	0	3	1	15	13	5
Previous employment as a disabled worker in a sheltered workshop	0	1	0	8	20	8
(B). Larger countries						
Experience in industrial management	4	7		6	2	0
Experience as an industrial worker	2	7		5	2	3
University degree	0	2		8	6	3
Training or experience in social work	2	5		9	1	2
Training as a physician	0	0		3	10	6
Training or experience in physical medicine and rehabilitation	0	0		3	10	6
Experience in the employment of the handicapped in fields other than sheltered employment	3	2		9	3	2
Managers are physically handicapped themselves	0	3		11	4	1
Previous employment as a disabled worker in a sheltered workshop	0	0		7	8	4

c. Recommended qualifications. We asked our informants whether they believed that workshop managers ought to have certain qualifications. The results appear in Table 19. Substantial numbers believe that experience in industrial management, social work, and employment of the handicapped are good qualifications for workshop management, with principal emphasis on industrial management. Few thought that full medical training was particularly important, although several favored prior experience in physical medicine and rehabilitation (Apparently they interpreted such training as not involving a full medical education.)

d. Training courses. Nine of the thirty-seven countries in our survey have special courses for managers, foremen, or other personnel. Some of the training is brief: occasional courses are offered by the Labour Department of Hong Kong; a special course in work therapy offered to physicians in the German Democratic Republic includes some instruction about sheltered employment. Some countries have more extensive offerings: the Swiss federation for vocational rehabilitation (SAEB) each year conducts a one-week course for managers and foremen; the National Rehabilitation Center of the Ministry of Labour of Norway gives short courses of three to six days duration to about thirty managers annually.

Two countries have quite elaborate courses for managers. A private organization in the Netherlands has just begun a two-year course for managers. The optional prerequisites are graduation from technical school and from a two-year course for workshop foremen that has already existed in Holland for several years. Two university curricula for managers began in the United States in September 1964. The University of Wisconsin gives a two-year course for college graduates, offering an M.A. degree. The University of San Francisco provides a nine-month course, with award of a certificate at the end.

Table 19

Recommended Experience and Training of Managers

Background	All Countries	Larger Countries
Experience in industrial management	30	16
Experience as an industrial worker	11	7
University degree	6	4
Training or experience in social work	20	11
Training as a physician	0	0
Training or experience in physical medicine and rehabilitation	9	4
Experience in the employment of the handicapped in fields other than sheltered employment	18	8
Managers are physically handicapped themselves	8	5
Previous employment as a disabled worker in a sheltered workshop	5	2
Number of countries answering the question	34	18

e. Associations. Only Switzerland, Sweden and Japan have professional associations for workshop managers. The Schweizerische Verband von Werkstätten für Behinderte is a member organization of the Swiss federation for vocational rehabilitation (SAEB).

Chapter 7: LABOR

a. Hours of work. The working schedules of sheltered workshops show very wide variations among countries. There are great differences in the number of hours expected of disabled workers, whether sheltered workers are handled differently from normal workers, whether the more and less severely disabled are systematically scheduled differently, and whether particular disablilities are given special hours of work.[21]

In seven countries, all sheltered workers generally have the same schedules as those in open industry:

	Days per week	Hours per day
India	5 1/2 to 6	8
Indonesia	6	7
Mexico	6	8
The Netherlands	5	9
Philippine Islands	5	8
Venezuela	6	8
Yugoslavia	6	7 to 8

Our Dutch and Yugoslav informants remarked that working hours in individual cases can be reduced to four a day or more, depending on capacity. Yugoslav workshops and their disabled employees follow normal schedules because the other half of the employees are healthy: emulation of the normal worker is the reason for mixing them.

In six countries, nearly all sheltered workers follow the same schedules as normal workers, without systematic differentials between the more and less severely disabled, but with some exceptions for particular categories of disability:[22]

	Normal Workers	Exceptional Disability	Schedule for Exceptional Disability
Belgium	5/8-9	Mentally ill; retarded adults	Variable from part- to full-time
Eire	5/8	Tuberculosis; cerebral palsy; arthritis	5/4 - 8
Great Britain	5/8	Tuberculosis	5/4 - 8
Hungary	6/8	Tuberculosis	6/6
Poland	6/8	Cardiovascular; retarded adults	6/6
		Tuberculosis	6/6 - 7
		Mentally ill	6/4 - 6
United States	5/8	Retarded adults	5/6
		Tuberculosis	5/4 - 8

Hungary may soon introduce greater differentials, according to category of disability.

In four countries, all sheltered workers follow similar schedules regardless of level of severity, but all work shorter hours than do normal workers:

	Normal Workers	Sheltered Workers	Exceptions
Burma	6/8	5/8	More disabled paraplegics 5/4
Hong Kong	7/9-10	$5\frac{1}{2}$/7	Blind 5/7
Israel	6/8 (4 hrs on Sunday)	6/7	
Lebanon	$5\frac{1}{2}$/8	5/6	

In four countries, all or most sheltered workers have lighter schedules than the normal; sheltered workers differ according to nature of disability, but they work similar schedules regardless of severity:

Pakistan: Normal workers 6/7
  Blind, deaf 6/4-5
  Tuberculosis 6/2-3
  Lepers 5/4-5

Spain: Normal workers 6/8
  Blind 6/7
  Amputees, paraplegics, tuberculosis, cerebral palsy, cardiovascular, arthritics, epileptics 6/6

Switzerland: Normal workers $5\frac{1}{2}/8$
  Amputees, blind, deaf, cerebral palsy, arthritics, epileptics, retarded adults 5/8
  Paraplegics, tuberculosis 5/4-8
  The only differential by severity is for retarded children: more severely disabled 5/4-6, less severely 5/6-7

Viet Nam: Normal workers 6/7
  Blind 6/7
  Amputees, paraplegics $6/6\frac{1}{2}$
  Lepers 6/6

Six countries have differentials between the more and less severely disabled that follow a simple pattern with few exceptions:

	Normal Workers	Less Disabled	More Disabled	Exceptions
Argentina	5-5$\frac{1}{2}$/8	5/7	5/6	
Australia	5/8	5/6+	3/6	Blind, deaf 5/6+
Finland	6/8 (6 hours on Saturday)	6/8 (6 hours on Saturday)	6/6-8	Less disabled amputees 6/6-8
France	5/9	5/9	5/4-8	Less disabled amputees 5/8-9
Norway	6/8	6/8	6/4-8	
South Africa	5 and 6/8 or 7	5/8	5/7	More disabled cardiovascular 5/6; more disabled cerebral palsy 5/5

Four countries reported a complicated set of differentials varying both by severity and category of disability:

German Federal Republic: Normal workers 5-6/8-9

Less disabled: blind, deaf, elderly 5/8-9; amputees 5-6/6-8; cerebral palsy 5/7-9; mentally ill and retarded adults 5-6/4-9; epileptics and retarded children 5-6/4-8; paraplegics, tuberculous, cardiovascular 5/8; arthritics 5/6-8

More disabled: blind and deaf 5/8-9; elderly 5/7-8; mentally ill 5-6/4-9; amputees, retarded adults, retarded children 5-6/4-8; tuberculous, cardiovascular, cerebral palsy, arthritics 5/5-8; paraplegics 5/4-8; epileptics 5/3-8.

Ghana: Normal workers 6/8$\frac{1}{2}$

Less disabled blind and lepers 6/8

More disabled lepers 4/2-3

Japan: Normal workers 6/8

Less disabled amputees, paraplegics, blind, deaf, cerebral palsy, arthritics, retarded adults, elderly 5 $\frac{1}{2}$/7
Less disabled tuberculous 5 $\frac{1}{2}$/6.

More disabled amputees, paraplegics, blind, deaf, retarded adults 5 $\frac{1}{2}$/6. More disabled elderly 5 $\frac{1}{2}$/4. More disabled tuberculous, cerebral palsy, arthritics 5 $\frac{1}{2}$/2.

Turkey: Normal workers 6/8

All deaf and arthritics 6/6

Less disabled tuberculous 6/8. Less disabled lepers, epileptics, mentally ill, retarded adults, elderly 6/6. Less disabled amputees, paraplegics, cerebral palsy 6/4. Less disabled cardiovascular 3/6.

More disabled lepers and retarded adults 6/4. More disabled tuberculous and cardiovascular 3/4.

Sweden and the German Democratic Republic, our informants said, lacked any general rules. Work is determined according to individual circumstances and not according to clinical category.

As this involved review shows, the scheduling of sheltered workers varies enormously in the world. The number of hours per week, whether a disabled worker shall be expected to work as long as a normal person, whether degress of disability are managed differently, whether one or another disability is given special treatment--all these vary considerably among countries.

Our data asked about hours in the workshop and not about rest periods or work pace. Therefore, even if disabled persons in a country seem to be in the workshop an unusually long time, we do not know whether they are working with unusual intensity. This kind of information must be learned before one can make cross-national comparisons of work schedules.

b. Forms of pay. We asked about the formulae for paying workers in each country's workshops. Usually most of the country's workshop employees are paid according to one method, while smaller proportions are paid according to one or more of the other arrangements. Table 20 lists the number of countries that pay half or more of their workers by each method. More countries use piece rates than any other single system, while a basic wage is next most common.

A few countries have variations of the basic payment systems listed in our questionnaire. Nearly all Dutch employees are paid by the hour on the basis of merit ratings, with a guaranteed basic wage. Indian workshops pay a stipend or daily wage that is related to production. The stipend increases when output goes up, like a salary increase. Thus income is related to production, without the insecurities of piece rates.

Table 20

Methods of Paying Workshop Employees

Forms of Pay	Number of countries in which the majority of employees is paid in each of the designated ways: All Countries	Larger Countries
Entirely by piece rates (i.e., a distinct and additional payment for each object produced or for each act performed)	10	5
Payment by the hour	3	2
A basic daily, weekly, or monthly wage without extra payments by the piece or hour	9	3
A basic daily, weekly, or monthly wage supplemented by some piece rates	3	2
A basic daily, weekly, or monthly wage supplemented by hourly pay	0	0
Several different types of payment rather than one principal type	10	6
Number of countries answering the question	35	18

c. Supplements. Informants were asked whether the pay of workshop employees was supplemented by some form of public subsidy, thus enabling these personnel to earn a "social wage" higher than the workshop budgets can furnish. These subsidies would be distinguished from disability pensions under social security, which we investigated in later questions. In practice, the supplement is distributed to workshop employees and managers from public grants that are given in lump sums to the workshops and that are earmarked for wages.

Of the twenty-three countries answering the question, fourteen pay such supplements to the employees of workshops. (In addition, Belgium in 1963 enacted a law authorizing such subsidies, but it had not yet gone into effect at the time of our survey). In general, the money is paid to the workshops and subsidies the entire wage bill of the shop. Thus workers do not usually find the subsidy as separate items int their paychecks, although this is the method in some countries The proportion of workers receiving these public subsidies varies considerably among countries: about three-quarters or more in Canada, Japan, Holland, and France; about half in Finland and Hong Kong; nearly one-third in Great Britain;

about one-quarter or less in Argentina, West Germany, Lebanon, Pakistan, Spain, and Yugoslavia. The proportion of workers' total incomes contributed by these subsidies also varies greatly among countries: three-quarters or more in Holland; about one-third in Finland, Hong Kong, Japan, and Yugoslavia; about half in Canada and South Africa; between one-tenth and three-quarters in France, depending on the individual case.

Of the twenty-two countries answering the question, only six reported any sort of public subsidies for managers' wages. Such payments are said to be given to all managers in Canada, Holland, Japan, Norway, and South Africa; to about half the managers in Pakistan; and to about one-quarter in Lebanon. All Canadian and nearly all Norwegian managers are paid entirely this way rather than from workshops budgets; about three-quarters of the incomes of Japanese managers and half the incomes of Dutch managers come from such outside sources. In Lebanon, these sums are smaller.

A few governments, such as Hungary, provide economic assistance by reducing the taxes of the disabled, rather than supplementing their incomes with public grants.

d. Coverage under Social Security. Is employment in sheltered workshops equivalent to normal employment, in that the disabled workers build up the same eligibility for social security benefits as those offered to employees in normal industry? Table 21 summarizes our informants' reports. If the questionnaire responses are fully accurate,[23] health insurance, public medical care, sick benefits, compensation for loss of wages, and compensation for industrial accidents are the social security programs available to normal employees in the largest numbers of countries covered by our survey. But substantial minorities of countries may not extend these benefits to sheltered employees. Family allowances are available to normal employees in fewer countries, but coverage is more likely to include sheltered workers. Old age and retirement benefits are availabe to both normal and sheltered workers in many countries.

Table 21 presents the data for all countries and for the larger ones. By subtracting the latter from the former, one can compare the developed and underdeveloped countries. A larger proportion of the developed countries have social security programs. Of those with social security benefits, a larger proportion of the developed countries extend them to sheltered workshops.[24]

Table 21

Coverage Under Social Security

(A). All countries

	These Benefits Are Generally Available to:			Benefits are not Available to Any Workers
Benefits	Workers in Normal Industry	Sheltered Workers in Full	Sheltered Workers in Part	
Health insurance, medical care under social security	23	13	5	13
Sickness benefits, compensation for loss of wages	26	13	6	10
Compensation for industrial accidents	27	13	5	8
Disability benefits where disability does not arise from industrial accidents	20	11	5	16
Unemployment compensation	16	10	2	20
Old age and retirement benefits	23	15	4	14
Death benefits	14	7	3	21
Family allowance	20	12	4	15

(Part B continued on following page)

Table 21
(Continued from previous page)

(B). Larger countries

Benefits	These Benefits are Generally Available to:			Benefits are not Available to Any Workers
	Workers in Normal Industry	Sheltered Workers in Full	Sheltered Workers in Part	
Healt insurance, medical care under social security	15	10	3	4
Sickness benefits, compensation for loss of wages	17	11	3	2
Compensation for industrial accidents	17	11	4	2
Disability benefits where disability does not arise from industrial accidents	15	9	5	4
Unemployment compensation	12	8	2	7
Old age and retirement benefits	17	13	3	2
Death benefits	9	5	3	10
Family allowances	14	10	3	5

e. Continuation of disability benefits. One of the controversial issues in sheltered employment is whether disability benefits should continue to go to disabled persons after they begin earning wages from sheltered workshops. Table 22 summarizes the policies in the countries we surveyed. The countries with lower national incomes and with small workshop programs either have no disability pensions for anyone (e.g., Philippines, Argentina, India, Ghana, Turkey, and Burma) or have modest pensions and cut them off at once upon entry into workshops (e.g., Uruguay, Venezuela, Mexico, Lebanon, Trinidad, Indonesia, and Hong Kong). The larger and more affluent countries tend to reduce pensions or eliminate them if income passes a certain point.

Various formulae in social security laws govern the reduction of such benefits. In some countries, the pension is cut off completely if income rises beyond a particular sum: in Canada, $20 per month; in Japan, 180,000 yen (equal to $500) a year. Other countries have statistical yardsticks. For exemple, Swiss disability pensions are reduced if earnings exceed them by a proportion between 33% and

50% of the pensions, and presumably the pensions are eliminated if earnings exceed 50%. In some countries, certain disability pensions are retained in full while others are reduced. For example, Belgian and West German disability pensions continue to go to employed war veterans and certain others, while other disability pensions are gradually reduced as income rises. Switzerland bases reductions on physical capacity as well as on earnings: pensions are reduced if capacity reaches 50%, they are paid in full if capacity is less than 33%, and they are payable in part or in whole in the intermediate zone depending on the amount of economic hardship.

Table 22

Continuation of Disability Pensions

Question: Do workers in sheltered workshops continue to get a disability pension or rehabilitation allowance under social security?

	All Countries	Larger Countries
Pension is continued in full	4	3
Pension is cut off at once	9	2
Pension is reduced or is eventually cut off as income passes certain levels	17	13
Countries have no disability pensions	7	1
Total number of countries	37	19

We counted the United States among the countries reducing pensions, but American benefits continue for a substantial time. During the first year of his employment, the disabled worker can draw a full pension. It continues thereafter if he works part-time and his annual income is no more than $600. If his annual income exceeds $1,200, his pension stops. Between $600 and $1,200 is a discretionary area that is often decided on behalf of the disabled worker.

A few countries with larger programs, such as Canada and Yugoslavia, reported that they had special rehabilitation allowances. These are training grants and are not scaled according to the recipient's income. They are stipends offered in lieu of wages during training. Once the person's training ends and he becomes a regular workshop employee, his income is some combination of wages and a disability pension.

Our informants gave various reasons for the reduction or cancellation of disability pensions. Eight said that workshop clients were considered employed persons, and that social security principles in their countries forbade such payments to employees. Five said that without a reduction, disability pensions and wages would total more than the pay of normal workers. Seven said that reduction in the pension was designed to encourage the worker to move from the workshop into a more remunerative job in normal industry. But, as our French informant commented, implementing these policies raises dilemmas. In France, disability pensions are supposed to diminish if the workshop salary added to the pension exceeds the income of the year preceding the illness. But reduction of the pension weakens the motivation to enter sheltered employment--a tendency reported in several other countries. So, French policy-makers are exploring the possibility of giving the worker a larger fraction of the pension.[25]

We asked all our informants whether pensions should be continued or modified. Table 23 gives the results. Part A of the table contains the total distribution of results, and Part B gives the number of informants agreeing with certain reasons for modification that we had listed. Most favored lower pensions; the number preferring full pensions exceeded the number favoring complete elimination.

Table 23

Opinions about Continuation of Pensions

A. Question: Do you believe that workers should get no or lower disability pensions at the time they are at sheltered workshops?

Opinions	All Countries	Larger Countries
No disability pension	5	2
Lower pension than if they were unemployed	17	10
The same pension as if they were unemployed	9	5
Total number of countries answering the question	31	17

B. Question: If you believe disability pensions should be eliminated or reduced during employment in workshop, what are your reasons?

Opinions	All Countries	Larger Countries
As much as possible, such persons should be treated as normal workers supported by their own earnings	16	8
Continuation of disability pensions will discourage workers from seeking to enter normal jobs	13	6
Wages in workshops are adequate	6	3
Social security funds cannot afford unnecessary expenditures	2	0

As can be seen in Part B, the advocates of reduction or elimination believe that such a policy can be a successful part of a larger strategy encouraging the disabled to join the normal labor force. They believe that otherwise the disabled would not be motivated to move on to normal jobs. Some of the advocates of full pensions are also concerned with a larger manpower and rehabilitation design, but they believe that reduction of pensions would discourage the disabled from taking the necessary first step of entering a workshop. For example, our Viet Namese and French informants believed that many of their disabled citizens would become discouraged if they lost their pensions, since work was not so prized for its own sake. To prevent this, Viet Nam has already adopted the policy of retaining pensions in full.

Several informants amplified their recommendations of lower or no pensions:

> Disability pensions, benefits and wages shouldn't total more than the former earnings of the disabled person (Hungary).
>
> I believe disability pensions should be paid on a graduated scale so that pension and sheltered workshop earnings together total 2/3 or 3/4 of the basic wage on which awards are fixed. Benefits should be on a scale diminishing in accordance with increased sheltered workshop earnings, say a reduction of £ 1 of pension for each £ 2 earned in a sheltered workshop would increase incentives (Australia).
>
> Pension is primarily designed for help of the unemployable handicapped. Employable workers in the sheltered workshops should support themselves by their own earnings as much as possible. The lower pension is for the partially self-supported vorkers as their subsidies (Japan).

> It all depends on the character of the allowance. If it is accorded to a degree of "wants for the poor," then obviously the amount of allowance should be reduced gradually in proportion to the increased earnings (Belgium).

f. Compulsion. Another of the controversial issues in sheltered employment is whether disabled persons should be induced to enter sheltered employments by means of pressures as well as incentives. One possible method is to withhold disability benefits, pension rights, and other public assistance from those who refuse. Of the twenty countries who have such social security aid and who answered our question, sixteen said that handicapped persons refusing to enter sheltered employment run no such risks. Disability pensions and rehabilitation allowances may be lost completely in South Africa, Sweden, Switzerland, Yugoslavia, and the United States, and they may be reduced in the Netherlands. Actual revocations of benefits occur rarely in these countries: either because of personal ambition or awareness of possible penalties, the disabled rarely refuse sheltered jobs; adminstrators tend to view the apathetic disabled as problems for treatment rather than for discipline; the administrative procedure for investigating cases and suspending benefits is so cumbersome in the United States that officials rarely use it.

We asked our informants whether disabled persons refusing sheltered employment should lose any social security benefits. Eighteen said they should lose none. Three believed that some benefits should be lost completely, and seven thought that some benefits should be reduced. Opponents of the cancellation of benefits based their position on humanitarian grounds: the disabled "would have insufficient income to survive," said our Australian informant. Some of the proponents of reduction commented:

> Yes, if the work to be performed is suitable and not humiliating for the individual concerned (Netherlands).
>
> Yes, but he should be examined to see why he refuses. He must be stimulated to work and his family protected if he is wrong (Yugoslavia).
>
> If someone is physically capable of working, he shouldn't be allowed to elect to remain idle and draw the taxpayers' money. The truth is that some workshops pay low, and I wouldn't blame them for refusing. But I would reduce pensions, if wages are adequate for livelihood (United States).

g. Ratings of performance. Most of the workshops in most of the countries surveyed may have some sort of evaluation of the performance of workshop employees. Among the criteria used are the client's quantity and quality of work, devotion to work, attitude toward fellow workers, and care for materials. However, as some informants remarked, most of these judgments result from common-sense observations of the worker by the workshop manager, foreman, and other staff members. Probably not many workshops in the world have highly formal systems for evaluating the work performance of employees.

Table 24 summarizes the rewards given to the more efficient and more conscientious workers. The most common gain is more money. Although India and the United States do not offer any of the special rewards on the list, their remuneration systems are so constructed that the better workers earn more: since salary is related to output in Indian workshops, the more productive usually get pay increases; since most American workers are on piece rates, higher output automatically increases their incomes.

Table 24

Rewards for Superior Workers

Question: If merit ratings are used, are the high-ranking workers rewarded by any of the following methods?

	All Countries	Larger Countries
Money Bonuses	23	13
Job promotions within the workshop	15	10
Extra time off with pay	4	2
Public commendations, such as written citations, medals, etc.	7	4
No special rewards exist	4	2
Number of countries answering the question	32	15

h. Absences. Table 25 reports the measures taken if a worker is repeatedly absent. The principal consequences are loss of wages and referral to a physician, social worker, or vocational counsellor. In most cases, the loss of wages is automatic, as in normal employment. But in some countries, the special circumstances of vocational rehabilitation govern the decision: in Switzerland, wages are deducted only after a long absence; in Yugoslavia, they are lost only if a physician or social worker has found that the absence was unjustified.

A persistent absentee can be discharged from the workshop, but several of our informants remarked that this happens rarely. A few countries have goverment rehabilitation officers who receive referrals of absentees: for example, most American clients are sent to workshops by state rehabilitation agencies; their vocational counsellors oversee the performance of these workers and investigate excessive absences.

Table 25

Results of Repeated Absences

Question: If a worker is absent often, which of the following consequences usually occur?

	All Countries	Larger Countries
Loss of wages for that time	33	18
Loss of disability pension	0	0
Loss of other social security benefits	2	1
Referral to a physician or psychiatrist	17	9
Referral to a social caseworker	23	12
Discharge from the workshop	18	9
Total number of countries answering the question	37	17

i. Dispositions. Table 5 summarized our informants' reports about the actual functions of sheltered workshops, and the provision of permanent employment was clearly paramount. This is evident too in the estimates of annual turnover of workshop personnel. Table 26 summarizes the proportion of workers who remained in sheltered employment at the end of each year, and the proportions who passed into open industry. In the largest number of countries, very high proportions remained in workshops and one-tenth or fewer secured open jobs. (In our original question, the remaining percentages died, returned to hopitals, returned to their families, or dropped out in some other way.)

Table 26

Annual Dispostitions of Workshop Employees

	All Countries	Larger Countries
Percentages Who Remained in Workshops:		
90% and over	3	2
75% to 89%	11	4
50% to 74%	8	5
Less than 50%	2	1
Percentages Who Entered Regular Jobs in the Economy		
5% and less	7	4
6% to 10%	10	4
11% to 20%	4	3
Over 20%	3	1
Number of Countries Making Estimates	24	12

Yugoslavia has an unusual pattern: less than half the disabled spend more than one year in a sheltered workshop and about a third pass into regular employment. Yugoslavia also has an unusual system of mixing both disabled and normal workers in workshops, in approximately equal proportions. Further study should be undertaken to determine whether the unusually high rate of rehabilitation is due to the mixing system or is due to the selection for sheltered employment of an unusually promising clientele.

Another exceptional pattern is Norway's. This is the only country where the number staying in workshops each year is exceeded by those who get regular jobs.

Chapter 8: HOMEBOUND WORK

Table 27 lists the twenty-one countries reporting that they had organized programs of work for homebound persons for the disabled.

Table 27

Organized Homebound Programs

Country	Number of Workers	Basis of Data
Australia	500	approximation
Belgium	350	approximation
Canada	500	approximation
Denmark	500	approximation
Finland	7,000	approximation
France	100	approximation
German Democratic Republic	unknown	
Ghana	15	exact statistics
Great Britain	1,100	approximation
Hong Kong	60	approximation
Hungary	8,000	approximation
Israel	100	approximation
The Netherlands	203	approximation
Norway	450	approximation
Philippine Islands	4	exact statistics
Poland	13,242	exact statistics
Spain	35	approximation
Sweden	860	exact statistics
Switzerland	unknown	
United States	unknown*	
Yugoslavia	700	approximation

---

* America has too many unrecorded homebound programs to admit of a simple national estimate. Only one survey has ever been conducted, and it is now out of date. Many of the programs at that time are described and their clienteles are estimated in M. Roberta Townsend et al., Study of Programs for Homebound Handicapped Individuals (Washington: United States Government Printing Office, 1955), pp. 61-74.

The following fourteen countries said on their questionnaires that they lacked homebound work for the disabled: Argentina, Burma, Eire, India, Indonesia, Japan, Lebanon, Mexico, Pakistan, Trinidad, Turkey, Uruguay, Venezuela, and Viet Nam. (Probably most of the countries who wrote us that they lack sheltered workshops also lack homebound programs).

Table 28 shows the categories of disabled who work in the homebound programs in the countries where our informants had some inpression of the composition of the work force. Most systems include the physically disabled, but fewer embrace the mentally handicapped. The elderly are included in many. In some countries, such as the United States, the blind and deaf would work in homebound programs only if they had other disabilities too; otherwise they would be in sheltered workshops.

A few informants were able to estimate the proportions of the homebound labor force suffering from various disabilities, and their reports appear in Table 29. As can be seen in the percentage distributions, the blind and persons suffering from limb disabilities predominate in many programs.

Our questionnaire did not ask about the organization of homebound programs, but some of our informants appended comments. A future trend may be to attach homebound programs to sheltered workshops. A new Belgian law requires sheltered workshops to conduct homebound programs, as a condition for receiving grants from the government. France is planning "Centers for Work Distribution at Home," attached to sheltered workshops. A recent survey of American sheltered workshops showed that over a fifth sponsored work for the homebound.[26]

Table 28

Types of Disabled Person in Homebound Programs

Disability	Number of Countries
Amputees and other limb handicaps	11
Paraplegics	11
Persons recovered from tuberculosis lung diseases	10
Persons recovered from cardiovascular disease	9
Blind	12
Deaf	6
Persons suffering from leprosy	1
Persons suffering from cerebral palsy	10
Arthritics	7
Epileptics	10
Mentally ill and persons recovering from mental illness	7
Mentally retarded adults	6
Elderly	10
Total number of countries answering the question	16

Table 29

Distribution of Homebound Workers by Disability

Disability	Belgium	German Democratic Republic	Ghana	Hong Kong	Netherlands	Poland	Spain	Sweden	Yugoslavia
Amputees and other limb handicaps	?	28%	--	50%	--	10%	29%	( ) (48%)	6%
Paraplegics	?	6	--	--	--	--	59	( )	4
Persons recovered from tuberculosis and other lung diseases	--	6	--	17	--	11	--	5	17
Persons recovered from cardiovascular disease	--	6	--	--	--	15	--	?	4
Blind	43%	2	100%	--	26%	2	12	1	23
Deaf	--	1	--	--	--	--	--	11	3
Persons suffering from leprosy	--	--	--	33	--	--	--	--	--
Persons suffering from cerebral palsy	?	3	--	--	--	10	--	?	1
Arthritics	?	--	--	--	--	--	--	( ) (15)	4
Epileptics	?	5	--	--	--	2	--	( )	1
Mentally ill and persons recovering from mental illness	--	18	--	--	--	--	--	( )	8
Mentally retarded adults	--	--	--	--	--	--	--	(12) ( )	10
Elderly	--	3	--	--	--	17	--	2	9
Unspecified but belonging to above categories	57	22	--	--	74	33	--	6	9
	100%	100%	100%	100%	100%	100%	100%	100%	100%
Total number of sheltered employees forming the basis of these estimates	350	177	15	60	203	11,477	35	860	700

The base numbers and the percentages should be interpreted as approximations rather than as exact statistics. The East German statistics are only for the Heimarbeitzentrale, a division of the Rehabilitation Center of the Berlin-Buch Hospital; the best-organized homebound program in the country, it will be the model for others in forthcoming years.

SUMMARY

Many countries have set up sheltered workshops, and the number will continue to increase in the future. The numbers of workshops and of employees vary considerably among countries: some have hundreds of workshops and thousands of employees, other have but a few special workshops totalling less than a hundred clients. In general, the countries with higher national incomes and with the greater numbers of war casualties have the more developed programs (Chapter 1a).

The definition of "sheltered workshop" varies somewhat across national boundaries, although the basic ideas are similar. Some countries extend the definition to include establishments employing normal as well as handicapped workers. Others include programs for the elderly, children, and lepers, when many countries might consider them forms of remunerative occupational therapy (Ch. 1a). Among the establishments universally considered to be "sheltered workshops," wide variations exist in average size, composition, goals, medico-social functions, management, labor conditions, scheduling, output, etc.

Limb disabilities, tuberculosis, and blindness are included in sheltered employment in nearly all the countries surveyed. The larger countries' programs include mental illness, epilepsy, and retardation too. The small countries tend to have a few special workshops and thus concentrate on a few disabilities; the larger countries have more general workshops that can cover a greater range of handicaps. The proportion of sheltered employees with each disability varies widely among countries (Ch. 1b).

All countries in our survey include women as well as men in sheltered employment, and most assign both to the same work rooms. Few countries employ disabled children (Ch. 1e).

In most countries, sheltered employment is defined primarily as the provision of a permanent livelihood for the disabled who cannot be employed privately. Many countries mentioned rehabilitative functions as secondary aims. Many of our informants would favor in the future a greater stress on rehabilitation and on the provision of a transitional work experience, but many others still favor designing sheltered workshops in their countries primarily for those who can never enter the outside labor force (Ch. 2).

In most of the countries in our survey, private voluntary associations own and administer the majority of the workshops. Public ownership is common in some countries and may become increasingly important in the future (Ch. 3a). In most countries, workshops are administered separately from other establishments, but some countries have a pattern of integrating them with hospitals, homes for the disabled, and rehabilitation centers (Ch. 3b).

In no country are all workshops self-supporting, and all or most workshops need operating subsidies in a majority of the countries. National and local governments are the principal sources of such grants, and their importance will doubtless increase further (Ch. 3c).

Besides providing operating subsidies, many national and local governments affect workshops by providing grants for construction and equipment and by requiring workshops to meet certain standards. Where they exist, such government regulations usually are designed to protect the employees by fixing maximum hours, rest periods, safety and sanitation, and the provision of medical services by the workshops (Ch. 3d).

Several countries provide medical and social services to the employees of workshops--but perhaps not as many as might be preferred by advocates of the newest trends in vocational rehabilitation. Some countries locate these services in the workshops themselves; in others, employees are examined and treated by other agencies. Regular medical examinations are common, but occupational therapy, physiotherapy, vocational testing, and vocational guidance are found less often (Ch. 4a). Systematic evaluation of physical, mental, and work capacities before, during, and at the end of employment are practiced widely in some countries but not in all. Evaluation of ability to work may be more common than evaluation of physical and mental ability. The workshop foreman and social workers participate in these evaluations in many countries, but other professionals do so much less often (Ch. 4b, c, d).

Many countries sell their workshop output primarily in the open market, others depend on contracts. The trend is toward increasing reliance on contracts (Ch. 5a). Usually prices are competitive with the output of open industry (Ch. 5c). Most countries label a fraction of their workshop output, but many label none.

Most of our informants opposed all labelling (Ch. 5d). In about half the countries, some government agencies and some private businessmen give preference to the output of sheltered industry, provided the prices are competitive. Preferential buying of more extensive output is rare (Ch. 5e).

Special training for workshop managers has begun in only a few countries, and therefore the backgrounds of managers are heterogeneous. Prior experience in industrial management and in social work is most common (Ch. 6a, b).

Work schedules vary greatly among countries: disabled employees are treated quite differently from one country to the next with respect to their presumed capacity to match normal work days, number of hours, distinctions among degrees of disability, and special exemptions for certain conditions (Ch. 7a). More countries use piece rates than any other system of pay for a majority of their sheltered workers. A basic wage is next most common (Ch. 7b).

Sheltered employment is covered by social security in many countries, particularly in the more developed ones. Health insurance, sick benefits, compensation for loss of wages, and compensation for industrial accidents are the benefits most often extended to sheltered as well as to normal employees (Ch. 7d). Disability pensions usually are reduced or cut off completely, as sheltered employees' wages rise. Most of our informants favored continuation of pensions at a reduced rate; most of the others favored continuation in full (Ch. 7e). Usually threats to withhold disability pensions or other benefits are not used to compel persons to enter sheltered employment (Ch. 7 f). Usually chronic absenteeism leads to loss of wages, referral to a doctor, or referral to a social worker, but not to loss of benefits (Ch. 7h).

Annual turnover is low in sheltered employment in most countries. Only in a few countries do substantial proportions move on into open industry (Ch. 7i).

Slightly over half the countries in our survey reported organized work programs for the homebound. In some countries, no more than several dozen persons are involved, but elsewhere the totals are in the thousands. Too few statistics have been gathered to convey the client composition and organization of these programs (Ch. 8).

FOOTNOTES

1. Perhaps the most influential set of seolutions is Recommendation 99 "Concerning Vocational Rehabilitation of the Disabled," adopted by the International Labour Conference of 1955. See also "Conclusions of the International Seminar on Sheltered Employment," International Rehabilitation Review, January 1965, pp. 14-16.

2. The methods of this survey are described in more detail in William A. Glaser, "International Mail Surveys of Informants" Human Organization, Volume 25, Number 1. Spring 1966, pp. 78-86. At the time the study was contemplated, many assumed that we could expect our informants to fill out only brief questionnaires, with a resultant small return in information. But the study demonstrated that -- if money, support, and a professional research staff are available -- it is feasible to conduct a thorough survey with a long and probing questionnaire. The key to this success, of course, was the conscientious work of the informants in all the participating countries.

3. For more detailed information about sheltered employment and sheltered workshops in individual countries, see European Seminar on Sheltered Employment (The Hague: Nederlandse Centrale Vereniging voor Gebrekkigenzorg, 1959); Rehabilitation of the Disabled in Fifty-One Countries (Washington: Vocational Rehabilitation Administration, U.S. Department of Health, Education and Welfare, 1964), passim; Bundesministerium für Arbeit, Rehabilitation in England (Stuttgart: Georg Thieme Verlag, 1957), Chapters II and III; Report of the Working Party on Workshops for the Blind (London: Her Majesty's Stationery Office, 1962); Nellie Z. Thompson (editor), The Role of the Workshop in Rehabilitation (Washington: The National Association of Sheltered Workshops and Homebound Programs, 1958); Francis Sandmeier, Die berufliche Eingliederung Behinderter in der Schweiz (Zurich: Schweizerische Arbeitsgemeinschaft zur Eingliederung Behinderter in die Volkswirtschaft, 1961); F. Nüscheler, Description of Sheltered Workshops in Switzerland, SAEB Mitteilungsblatt, Number 87, 28 August 1964; E. Holstein and K. Renker (editors), Arbeitserfolge auf dem Gebiet der Rehabilitation in der Deutschen Demokratischen Republik (Berlin: VEB Verlag Volk und Gesundheit, 1962); Aleksander Futro, Invalids' Co-Operatives in Poland (Warsaw: Zaklad Sydawnictw CRS, 1964); The Society and Home for

Cripples in Denmark (Copenhagen: Samfundet og Hjemmet for Vanføre, 1963); "Ett Kvarts Sekel Invalidsamarbete," Invalidens vår (Finland), 1964, pp. 10-17, 31; A. Maron, "Rehabilitation Problems in Belgium," Rehabilitation, Number 45 (April-June 1963), pp. 37-43; Fathema Ismail, "Industrial Workshop of the Physically Handicapped," Samaj Seva (India), Volume II, Number 7 (april 1961), pp. 38-46; J.S. Maritz, "Rehabilitation within the Framework of Sheltered Employment," Rehabilitation in South Africa, Volume 5, Number 4 (December 1961), pp. 184-190; Rehabilitation of the Physically Handicapped in Japan (Tokyo: Japanese Society for Rehabilitation of the Disabled, 1965), esp. pp. 125-128; occasional articles in Bulletin de la Fédération Internationale des Mutilés et Invalides du Travail et des Invalides Civils.

4. About 7,000 disabled Dutch citizens worked in horticulture, the improvement of recreational amenities, and other open-air tasks in June 1963, according to our Dutch informant.

5. Countries also differ in the proportions of their disabled in sheltered employment. But no one knows these percentages, since few countries have done national health surveys. Thus Table 1 can merely compare sizes of programs, but it would be more interesting to compare effective scope. Probably no more than a small fraction of the disabled of each country is in sheltered employment. Even in a country with a highly developed program, relatively few disabled workers have any contact with rehabilitation services: see A.J. Jaffe et al., Disabled Workers in the Labor Market (Totowa, New Jersey: The Bedminster Press, 1964), pp. 23-24, 35-43, 91-93.

6. For example, Alfred Feintuch, "Classification of Sheltered Workshops," Occupations (Washington), Volume 29, Number 7, April 1951, pp. 515-517.

7. As will be evident throughout this monograph, the workshops of many countries lack the defining characteristics listed in the well-known "A Statement of Principles" issued in April 1961 by the Advisory Committee on Sheltered Workshops, Wage and Hour and Public Contracts Divisions, United States Department of Labor.

8. The decision to include the elderly may make a great difference. Our Japanese

informants included the programs in homes for the aged, but these accounted for 70 of the country's 380 workshops, and 10,000 of the country's 18,700 employees. In attempting to decide what were and were not workshops in their country, our Japanese informants began with a well-known American definition, noted that no Japanese workshop met all the criteria, and then counted those Japanese workshops that came reasonably close in certain essential respects. Similar careful reasoning -- with all its effort and complications -- would be necessary in making future cross-national comparisons. The Japanese informants used the definition in Sheltered Workshops and Homebound Programs: A Handbook on Their Establishment and Standards of Operation (New York: The National Committee on Sheltered Workshops and Homebound Programs, 1952).

9. Yugoslav sheltered workshops employ 4,000 persons who are disabled and 4,000 who are not disabled. Our Yugoslav informant summarized for us the philosophy underlying the system: "We consider that the equal number of disabled and healthy helps the handicapped to work in a normal environment and to become accustomed to normal conditions and sphere of the work for his future. This saves him from all kinds of isolation or discrimination, that otherwise would occur if the disabled worked alone. This system also provides better financial conditions for sheltered workshops. Finally, the system gives to the severely handicapped the possibility of being supported by non-disabled persons during their work."

10. For example, Ruth Friedman, "Inside Russia Today: Preparing the Blind to Lead Useful Lives," Journal of Rehabilitation, Volume XXVIII, Number 1 (January-February 1962), pp. 13-14, 52, 55-57.

11. A survey of American workshops discovered that most were smaller than expected. Over one-third had between eleven and thirty employees, half were smaller than forty. But a few had more than three hundred employees apiece. Report of Nationwide Survey of Sheltered Workshops (Washington: Rehabilitation Facilities Staff, Vocational Rehabilitation Administration, Department of Health, Education and Welfare, 1961), p. 5.

12. This question was debated at the European Seminar on Sheltered Employment, pp. 17, 97-99, 108, 117.

13. For example, Edward L. Chouinard and James F. Garett (editors), Workshops for the Disabled (Washington: Office of Vocational Rehabilitation, U.S. Department of Health, Education and Welfare, 1956), pp. 7-10, 15-17, 26-27, 147-154.

14. European Seminar on Sheltered Employment, pp. 36-39, 158-160.

15. In most countries the same organization is the founder, owner, and manager of a workshop. But in Yugoslavia, the founding organization is distinct from the currently responsible body, which is an autonomous worker's council combining representatives from the employees (constituting a majority of the council), from the founding organization, and from other competent local authorities or rehabilitation institutions. In Table 7, I have entered the Yugoslav data according to the identity of the founding organization. The ownership and control of Yugoslav workshops is described in Collection of Regulations on Vocational Rehabilitation of Disabled in Yugoslavia (Belgrade: Secretariat of the Federal Executive Council for Health and Social Policy, 1962), pp. 79-116.

16. For example, the discussion in the Report of Seminar on the Theme: 'Sheltered Workshops' (Adelaide: The Australian Council for Rehabilitation of Disabled, 1963), pp. 21-38, 75.

17. "Carnet de la législation sociale dans le monde," Bulletin de la Fédération Internationale des Mutilés et Invalides du Travail et des Invalides Civils, Volume 7, Number 4, December 1963, pp. 157-159.

18. The relative merits of the two approaches were discussed at the European Seminar on Sheltered Employment, pp. 71-74, 79, 89-90, 93.

19. It is important to learn the extent and consequences of the adoption of newer industrial tasks for certain categories of disabled persons, and there-fore the subject should be investigated in any future research.

20. Possibly some countries have several workshop managers with previous training in occupational therapy--as our Australian informant said of her own country--but our questionnaire did not include this category.

21. For each of the clinical disabilities listed earlier in this monograph, informants were asked to estimate the "number of days per week" and the "number of hours per day" for "the more severely disabled" and "the less severely disabled." Most informants (e.g., the list headed by Argentina) gave separate hours under the "more severely" and "less severely" headings. A few (e.g., the lists headed by India and Burma) said that all workers had the same hours, except for some individual cases of severe disability; they did not fill out the "more severely" and "less severely" columns separately. We shall treat the Argentine and Indian types of response as separate patterns, although possibly they reflect the same practices. To know definitely whether the former group of countries distinguish by severity far more than the latter group would require either full statistics about work schedules or a personal investigation of all by one interviewer.

22. For simplicity in presentation, I shall present working schedules as pairs of numbers. 6/8 means six days a week, eight hours a day. 5/8-9 means five days a week, eight to nine hours a day. 5 1/2-6/8 means five and one-half to six days a week, eight hours a day.

23. The phrasing and response procedure for this question may have been too complicated and therefore the answers may contain errors. If the responses had followed our intentions we could unambiguously classify countries into those without a particular social security benefit, those with the benefit for normal workers alone, those with full benefits for normal and sheltered workers, and those with full benefits for normal workers and part benefits for sheltered workers. But some failures to answer one or all items in the question lead to uncertainty in interpretation. We intended "in part" to identify countries where sheltered employment led to eligibility for partial but not complete benefits--e.g., sick benefits at a lower than normal rate--but we cannot be certain that some informants did not interpret this to mean that some sheltered employees were covered in some form while some were not.

24. Our survey asked whether regular social security benefits are extended to workers in sheltered employment. In a few countries, social security agencies maintain or subsidize sheltered workshops. They are described in Ida C. Merriam, Social Services Provided by Social Security Agencies, Members of the I.S.S.A. (Geneva: International Social Security Association 1964), pp. 41-44.

25. Dilemmas like this were discussed at the European Seminar on Sheltered Employment, pp. 26, 102-104. For an illuminating debate on the problem of achieving the right balance between wages and pensions, see Report of Seminar of the Theme: "Sheltered Workshops" (Adelaide: The Australian Council for Rehabilitation of Disabled, 1963), pp. 48-68, 77-78.

26. Report of Nationwide Survey of Sheltered Workshops (Washington: Rehabilitation Facilities Staff, Vocational Rehabilitation Administration, Department of Health, Education and Welfare, 1961), p. 6.

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The first name for each country is the principal informant who prepared the questionnaire. Other persons on each list submitted information to him.

Argentina: Sra. María Inés Ottolenghi de Ure and Sra. Sara Harrington de Casas, Asociación de Ayuda y Orientacion al Inválido

Australia: Miss Jean Garside, Australian Council for Rehabilitation of Disabled.

Belgium: M. Jean Regniers, National Secretary for I.S.R.D. M. Armand Maron, Fonds National de Reclassement Social des Handicapés.

Burma: Dr. Hla Pe, National Association for Handicapped Children.

Canada: Dr. Keith S. Armstrong, The Canadian Rehabilitation Council for the Disabled.

Denmark: Mr. P. Hoeg Albrethsen, Society and Home for Cripples.

Eire: Mr. C.J. Sweeney and Dr. T. M. Gregg, National Organisation for Rehabilitation

Finland: Mr. Aarno Ranta, Finnish Association of Disabled Civilians and Servicemen
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Ghana: Mr. Joseph Sydney Adoo, Department of Social Welfare and Community Development

Great Britain:	Mr. Donald Pointon et al., Disabled Persons Branch, Ministry of Labour
Hong Kong:	Miss Daphne Ho, Social Welfare Department Mr. T. P. Khoo Mr. C. L. Choi
Hungary:	Professor Andor Glauber, University Orthopaedic Hospital, University of Medicine of Budapest Dr. Imre Vas, Rehabilitation Commission of the Health Scientific Council
India:	Mrs. Kamala V. Nimbkar, Society for the Rehabilitation of Crippled Children
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Mexico:	Dr. Jaime Orozco y Matus, Associacion Mexicana de Rehabilitacion
The Netherlands:	Dr. Anton H. Heering, Ministry of Social Affairs and Public Health
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Pakistan:	Mrs. Shireen Rehmatullah, Society for the Rehabilitation of Crippled Children
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Venezuela:	Dr. Carlos Bustamante B., Hospital Ortopédico Infantil
Viet Nam:	Dr. Le Van Thong, Association of the Friends of Vietnamese Disabled Veterans Association of Friends of Blind Vietnamese Veterans Legion
Yugoslavia:	Dr. Sulejman Masović, Institute for Physical Medicine and Rehabilitation, Zagreb.

The World Commission on Vocational Rehabilitation is an integral unit of the International Society for Rehabilitation of the Disabled. The International Society — a voluntary, non-governmental organization — is devoted to raising the level of rehabilitation practices and knowledge by assisting professionals and laymen throughout the world.

Men and women the world over who suffer from disabilities caused by diseases, accidents, emotional problems, are too often denied employment because of prejudice against the handicapped, lack of training, or through indifference and lack of knowledge concerning the abilities of the handicapped.

The disabled are relegated to inferior social positions; human talents are wasted; potentially productive people become wards of society. Ultimately, the entire community suffers.

EMPLOYMENT OF THE HANDICAPPED

Rehabilitation's goal is to help the handicapped person attain the fullest medical, social, educational, and vocational adjustment possible. Vocational rehabilitation encompasses guidance, training, and placement in employment.

The ultimate goal of vocational rehabilitation is to provide the handicapped individual an opportunity for total self-realization; to enable him to achieve dignity through his abilities and accomplishments — through employment.

The purposes of the World Commission on Vocational Rehabilitation are to: 1) Help the handicapped overcome vocational problems; 2) Increase employment of the handicapped; 3) Identify problems for research and study. Public information and education are major factors in WCVR's program. Summing up, WCVR's objective is employment of the handicapped on jobs consistent with their abilities.

The International Society welcomes requests for information and assistance. Write to:

International Society for Rehabilitation
of the Disabled
219 East 44th Street, New York, N.Y. 10017, U.S.A.

INTERNATIONAL SOCIETY FOR
REHABILITATION OF THE DISABLED

219 East 44th Street, New York, N.Y. 10017, U.S.A.
Phone: YUkon 6-1470 Cable: "INREHAB"

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INTERNATIONAL SEMINAR ON SHELTERED EMPLOYMENT

CONCLUSIONS

A Concepts, aims and principles
(The Hague Sem. Concl. par. 1-6)

1 Every handicapped person should enjoy the same right to work, according to his abilities, as any other member of society. Provision of employment is the main objective of vocational rehabilitation. If suitable work cannot be found under normal conditions on the open labour market it should be provided by means of sheltered employment.

2 By handicapped person in this connection is to be understood a person of working age and of reasonable working potential who, because of physical or mental impairment or other handicapping conditions, cannot, or can only with special help, secure or retain employment on the open labour market.

3 Sheltered employment, therefore, is to be understood as productive, remunerative employment of any type, supplied under conditions specially designed to meet the temporary or permanent employment needs of handicapped people.

4 Sheltered employment, being one of the aspects of vocational rehabilitation, should have always as a primary objective the provision of work. However, according to circumstances, it may be desirable and expedient to combine the provision of sheltered employment with other services essential to the vocational rehabilitation of the individual such as arrangements for adjustment and advancement.

5 When placing handicapped persons in sheltered employment due regard should be paid to the personal and vocational qualifications of the individual and local circumstances so as to help him to improve and maintain work capacity and likelihood of placement and to achieve a good work atmosphere and efficient production.

For this purpose professional services such as medical, psycho-social, educational, vocational and rehabilitation should be made available to the individual, within or outside the sheltered employment unit, as appropriate to the national and local circumstances.

B Responsibilities for Sheltered Employment
(The Hague Sem. Concl. par. 10-12)

6 The primary responsibility for sheltered employment rests with the State which should recognise that it has an obligation to see that sheltered employment is available for all those who need it. If it does not provide the leadership the State should encourage, inspire and help those who do.

7 To fulfill this responsibility the State should encourage or undertake the planning, co-ordination, organisation, administration and development of the national programme and should also be responsible for standard-setting, necessary legislation and research.

It should ensure that sufficient sheltered employment facilities are set up, either by the State itself or by local authorities or voluntary organisations. The State should co-ordinate the social security legislation and sheltered employment.

8 Financial and technical support from the State to local authorities and voluntary organisations may be given in various ways, for example:

a) loans or grants in aid for capital investment and working capital;
b) grants towards running expenses, including wages, costs of management, etc.;
c) grants towards expenses of research and planning;
d) tax exemption;
e) technical and other advice;
f) assistance in marketing.

Where financial support is given care should be taken to see that it does not perpetuate inefficiency and waste.

9 Trade unions and employers' organisations may be encouraged to take an active interest in sheltered employment programmes and to participate in the work of the appropriate advisory bodies. They can be drawn more closely into the work by including them in the boards of management of individual institutions and giving them a voice in the planning and running of national, regional and local services. Trade unions, through joint consultation and other means, have a particular part to play in matters affecting conditions of service and remuneration in sheltered employment schemes.

10 Employers (both private and public) may be encouraged to play a direct part by creating sheltered employment services within their enterprises. This should help to reduce the costs of sheltered employment and widen available facilities, and will have a favourable psychological effect on the disabled persons concerned.

11 International bodies - both governmental and non-governmental - should play a useful role in setting standards, conducting research, disseminating information and providing technical assistance and advice.

C Types of Sheltered Employment

(The Hague Sem. Concl. par. 7-9)

12 Various types of sheltered employment should be provided so as to meet the needs of the handicapped person: According to circumstances these types may comprise:

a) workshops or factories specially designed and run for the handicapped;

b) the execution of various types of open air projects;

c) the provision of individual jobs in public institutions or other organisations, provided the interests of the handicapped worker are safeguarded;

d) the provision of work in the home of the handicapped person, preferably organised by a sheltered establishment of type (a).

13 Sheltered employment may be provided by public authorities or voluntary organisations. Factories, workshops and other undertakings may also be created by co-operatives of the handicapped themselves or may be part of a firm in open industry. The latter should preferably serve also handicapped persons other than former employees of the firm.

14 In order to increase the range of possible work projects or for economic or psychological reasons, part of the workers in sheltered establishments may be recruited from non-handicapped persons.

15 The choice of the type of sheltered employment should depend on the requirements set forth in conclusion 5, with the understanding that, whenever desirable and feasible, special facilities should be provided to overcome the handicapped workers' difficulties in moving to and from their place of work. These facilities may be of the following kinds:

a) special transport to bring the workers to and from their place of work;

b) provision where necessary of accomodation of their own, in a private family or in a hostel. It is understood that family ties should be respected.

16 Unless homework is a normal feature of local economic life, the provision of work in the home of the handicapped person should generally be regarded as a last resort, because of the social and psychological disadvantages of keeping him in an isolated position, the danger of abuse inherent in homework and the organisational difficulties connected with it.

17 Persons belonging to various handicap groups should, unless otherwise indicated for medical, psychological, social and/or other practical reasons, be integrated in the same sheltered establishment, provided each placement is carefully considered on its individual merits, with a view to:

a) overcoming prejudices of handicap groups towards each other;

b) saving capital and running expenditure;

c) facilitating the recruitment of sufficient and competent management and supervisory staff.

D Production, Business Operation and Marketing
(The Hague Sem. Concl. par. 13-17)

18 Production in sheltered employment may be carried out either as work on own account or as contract work. Although the advantages of contract work generally outweigh the disadvantages,it is preferable to undertake a mixture of both types of work. This avoids over-dependence on one or more firms and the risk of loss of contracts in the event of a trade recession or technological change. It also results in a variety of work at different levels of skill.

19 Products of sheltered employment should be able to compete as to quality and prices with the products of normal industry. Undercutting of prices should be avoided, as should raising prices on charitable grounds.

20 Sheltered employment products should be advertised and sold only on the strength of their quality and price. It is not thought desirable to label goods as having been made by the disabled, but for products of a high quality there is value in having a recognised trade-mark.

21 The State may assist by authorising and encouraging sheltered employment organisations to bid for Government contracts and may award a reasonable proportion of such contracts to sheltered employment.

22 A central organisation may be useful for the purpose of buying and marketing. Such an organisation could help to co-ordinate the activities of sheltered establishments and could also play useful technical, consultative and research roles.

E Management and Staff Requirements

(The Hague Sem. Concl. par. 19-20)

23 Although sheltered employment has to fulfill humanitarian requirements it should be carried out on a commercial basis. Sheltered workshop management is technically little different from the management of a normal undertaking. It therefore calls primarily for properly qualified managers and supervisors. Appropriate technical skill, experience and qualifications are more important than previous experience with the handicapped. The number of supervisors, while varying according to the kind of work being done and the type of handicapped person employed, should be sufficient to ensure effective supervision.

24 Appropriate medical, psychological, social and placement services, should also be available, either in the sheltered employment programme or in the community. If these services are provided in the programme they should not be charged to production.

25 A physician should carry out examinations periodically and whenever necessary, and should give medical advice to the management on matters concerning the employment of the workers, including the type of occupation, hygiene and first aid. He should have a sound knowledge of employment problems generally and the special needs of the handicapped.

26 Those in charge of sheltered employment should have a sound knowledge of production, business practice, personnel management and, in particular, be adaptable and skilful in fully utilising the resources of specialist teams and advisers. Where possible they should receive the benefits of training in their responsibilities.

27 In the selection of handicapped persons for sheltered employment, use should be made of a team, composed of persons expert in various fields, and having a special understanding of the vocational needs of handicapped persons, such as a physician, a psychologist, a social worker, a placement officer. In addition the management of the sheltered establishment should always be represented. Before a decision is taken, the handicapped applicant should be given full opportunity to explain his views as to his placement in sheltered employment, either to the team as a whole or to members of it.

28 In the selection procedure, repetition of examinations and interviews should be avoided as much as possible by means of close co-operation among the agencies and specialists concerned, in particular regarding the exchange of all relevant information.

29 Job evaluation is necessary and should be carried out by a work study expert, the manager of the sheltered establishment and other experts working together as a team.

30 Part-time sheltered employment should only be considered for specific medical, psychological and/or social reasons provided that efficient production can be maintained.

G Conditions of Work

(The Hague Sem. Concl. par. 21-23)

31 Wage systems, including piece rating and merit rating, should be based as far as possible on national wage structures for normal employment, due regard being paid to the special requirements of sheltered employment. Where indicated these should be supplemented by other means so as to sucure an adequate standrard of living.

32 Incentives should be used to stimulate better work performance without impairing the health of the worker.

33 The workers´ health and safety should be protected by applying the standards applicable in normal industry.

34 Premises housing sheltered employment should be built or modified and equipped to make them readily accessible to and usable by the handicapped.

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